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ABSTRACT

This booklet presents the report of the Institute on Rehabilitation Issues, focusing on proprietary, or private for-profit rehabilitation. Following a list of the prime study group members, acknowledgements, and a brief preface, chapter I of the document presents an historical perspective on the rehabilitation movement in the United States, including public, private nonprofit, and private proprietary rehabilitation, the impact of worker's compensation, and economic issues. Chapter II focuses on perceptions, truths, and partial truths about proprietary rehabilitation from the viewpoints of rehabilitation staff, and in the areas of philosophy, work environment, service orientation, incentives, fees, marketing, and advocacy. Chapter III describes proprietary rehabilitation including providers, marketing, practitioners, services provided, program evaluation, and service delivery method. Chapter IV discusses the market place, i.e., federal, state, and insurance programs, and insurance industry players, e.g., claims adjusters, file managers, rehabilitation nurses. Chapter V focuses on rehabilitation of the injured worker from both a rehabilitation process and a psychological perspective. Chapter VI addresses issues such as service to worker's compensation clients, rehabilitation practices, funding of counselor training, professional standards, and interagency relations and their implications and considerations. The booklet concludes with a bibliography and an appendix containing the National Association of Rehabilitation Providers in the Private Sector's (NARPPS) Standards for Training and Experience, Standards and Ethics. (BL)

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Report from the Study Group on

PROPRIETARY REHABILITATION: A BETTER UNDERSTANDING

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St. Louis, June - 1983

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Proprietary Rehabilitation: A Better Understanding

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A debt of gratitude is owed to the Prime Study Group members who developed this document.

State vocational rehabilitation agencies contributed individuals with experience working with Worker's Compensation clients. Ken Fleming from Pennsylvania, James Scott from Michigan and Charles VanBoskirk from New York all provided unique perspectives, experiences and approaches even though they all represented public rehabilitation.

The Prime Study Group also contained three representatives from proprietary rehabilitation. Tom Brandon is President of Valpar Corporation based in Arizona and Kevin Karr is President of Karr Rehabilitation Services from Minneapolis, Minnesota. Rick LaFon was a representative from the National Association of Rehabilitation Providers in the Private Sector (NARPPS) and also owns his own consulting firm. They spoke with an intimate knowledge of the topic and were able to describe it well.

The viewpoints of self-insured employers were represented by Norm Silver, Manager of Human Relations at Tektronix Incorporated with headquarters in Beaverton, Oregon. (He has since retired and begun a management consulting group with several other individuals.)

The insurance industry was ably represented by Bill Maronek who is Director of Corporate Rehabilitation Claims for Sentry Insurance.

Finally, Carolyn Hoffman and Leonard Weitzman represented a large private nonprofit agency (Comprehensive Rehabilitation Center of Allegheny County in Pittsburg, Pennsylvania). Their center not only provides services to the vocational rehabilitation agency, but also provides similar services to third party payers (insurance companies).

The interchange between members of the group was instructive and positive. It is hoped that by sharing the results of our interchange in this document the rehabilitation movement will be strengthened and advanced.

Although methods and systems may vary, the ultimate purpose of all those engaged in rehabilitation is the same - to assist individuals with disabilities in the most professional and competent manner possible. This goal is great enough to form a broad base for mutual respect and professional cooperation in the sharing of knowledge and resources.

It is the hope of all the Study Group members that this document both enlightens the reader and makes a contribution to fostering understanding, respect and cooperation.

David W. Corthell, Ed.D.
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Prime Study Group

PREFACE

Over the past several years, the private or third party purchase of rehabilitation services has grown rapidly. George Wright (1982), uses the term "Proprietary Vocational Rehabilitation" to distinquish these services from those of the traditional public and nonprofit rehabilitation approach to providing services. Proprietary vocational rehabilitation may provide such services as consultation with attorneys, case management, expert testimony, nurse liaison agents, hospital cost auditing, and determination of the impact of disability.

The rapid growth of proprietary rehabilitation has been viewed by State/Federal vocational rehabilitation agency personnel with mixed emotions. Rehabilitationists in private practice have been received as fellow professionals and as rivals and competitors. As with many biases, these were often developed with limited direct knowledge of the subject.

Objectives:

The Institute on Rehabilitation Issues (IRI) Planning Committee asked the Prime Study Group to prepare a document describing proprietary rehabilitation. The Planning Committee listed the following objectives for the publication:

- Provide rehabilitation personnel current information about private rehabilitation.
- Assist interested individuals to differentiate the roles, functions, funding and service delivery systems of public and private rehabilitation agencies.
- Highlight exemplary practices which are of benefit to disabled individuals.
- Point out how public and private agencies can work together to benefit disabled people.

Study Group

The members of the Prime Study Group were selected to provide input

from the three major rehabilitation sectors; five represented the private sector, two represented the private, nonprofit sector; and there were four representatives from public rehabilitation. Care was taken so that the private sector included representation from the business and insurance communities as well as from private or proprietary rehabilitation companies. The Institute was extremely fortunate to acquire talented, busy, and knowledgeable people to develop the issue. The contributions by the private sector members were especially valuable, and IRI owes them a debt of gratitude.

Narrowing the Topic

It became clear early on that the entire field of private rehabilitation was too large to tackle. Private rehabilitationists provide many types of services including expert testimony, consultation, evaluations and evaluation systems. Consequently, the decision was reached to focus this document only on that part of private rehabilitation involved in providing direct client services. Therefore, topics like expert witnessing, consultation, case reviewing activities, and medical management were excluded. Trying to capture all the directions private rehabilitation is or might be going would be too difficult in a single document. As a result, this document attempts only to describe the state of the art of service provision in the proprietary sector.

There are many types of organizations involved in rehabilitation; state agencies, private proprietary business, private nonprofit corporations, insurance companies (both as purchasers and providers of rehabilitation services), self-insured companies and private individuals. An interesting recent phenomenon is a trend among private nonprofit agencies of selling their services not only to public agencies but also

to third party payers (i.e., insurance companies, Worker's Compensation programs, etc.) in competition with private-proprietary companies. In a very few instances public agencies have done, or are doing, the same.

When competing in this way, the forces which have shaped private-proprietary rehabilitation will similarly affect private nonprofit and public agencies. It is ultimately the payer and regulatory agencies who, in large part, control and influence how rehabilitation is provided in the proprietary agency. In contrast, public agencies services are influenced by public laws and public consensus regulates service provision.

The Document

The mix of emotions with which the various rehabilitation sectors have viewed each other also existed among the study group members. One problem that the group had to deal with was how to present the necessary information factually and yet communicate the feelings and conceptions, true or not, that exist.

An initial step was to get rid of unnecessary value-laden terms within the document. One such term is "private-for-profit." To some, the term connotes a mercenary attitude towards the rehabilitation of handicapped individuals. Study group members agreed that the motives for workers in all sectors are and will always be a mixture of altruism and self-interest. The public and private, nonprofit sectors do not have a corner on altruism, advocacy and commitment to serving the disabled. Consequently, it was recommended that the term "proprietary rehabilitation" be used instead. This term also distinguishes it from the public, nonprofit sector which has long been a partner with public rehabilitation.

Another major decision revolved around whether the contributions from the various members should be allowed to keep the author's

particular slant or bias. It was decided that this document, and ultimately the rehabilitation audience, would be better served by receiving a straight-forward factual presentation. Members argued that not to acknowledge the deep rifts between the various sectors would be dishonest, a disservice to the intended audience, and a loss of an opportunity to put some (mis)conceptions "on the table." A compromise was struck and a chapter was set aside to "clear the air" by stating some of the strongest myths, facts or fiction, that individuals from the various sectors feel about one another.

Diversity is the nature of a free enterprise system. Due to this diversity, some of the information in this document had to be general in nature.

Methods and systems may vary, and at times friction or competition may exist between the various rehabilitation sectors. Even so, the purpose of rehabilitation is always the same - to assist individuals with disabilities and handicaps in the most professional and competent manner at one's disposal. This goal is great enough and noble enough to form a broad base for mutual respect, professional cooperation and a sharing of knowledge, information and resources. Since respect and cooperation can only be validly based on knowledge and mutual understanding, it is hoped that this document makes a contribution in these regards. With these as a base, respect and cooperation cannot be far behind.

Competition within a free enterprise system is not necessarily bad. Within the private sector, companies are always looking for a competitive edge. This need to search for and use a competitive edge should not be limited only to the private sector. Public agencies can benefit by having

to fight for continued funding and support. Such pressures will force them to reexamine their own priorities, to identify their constituencies and to improve their accountability.

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Chapter I

Historical Perspectives

CHAPTER I

HISTORICAL PERSPECTIVE

During the twentieth century, we have experienced the inception, development and expansion of public vocational rehabilitation. However, the rehabilitation movement in the United States began prior to the initiation of public funding which began in the early 1900's. Perhaps the most effective "rehabilitation unit" that we have ever had was the traditional "nuclear" family. In our nation's early agrarian society, they assisted their family member "rehabilitants" with a variety of services including: medical care, medical care coordination, job-sharing, vocational exploration, retraining, self-employment plan development, work hardening, and counseling, to name a few.

With "progress" came the Industrial Revolution which led to enumerable changes in our agrarian society and nuclear family. The family, placed in an industrial setting, no longer had the same degree of flexibility in providing services to one of its members with rehabilitation needs. Due to the increase of injuries occurring as a result of industrial society and the reduction of death therefrom due to the concomitant advancement of medical science, the need for rehabilitation services steadily increased. As a result of this need, the State/Federal rehabilitation programs were established in the early 20th Century.

The original State/Federal rehabilitation program was established to service two principle populations, disabled veterans and the industrially disabled. In fact, it was found to be more dangerous to work in industry than to be a combat soldier in World War I. Over the years,

the program was expanded to serve many other populations. In addition, the scope of services offered through public programming expanded to more fully meet the needs of the handicapped population.

During the fifty year period ending in 1970, the predominance of vocational rehabilitation counseling and service coordination was supported through public funding. Since the 1970's, public sector rehabilitation growth has stablized and both private nonprofit and private proprietary programs have developed and expanded to meet market needs. Nevertheless, the current impact of public sector rehabilitation programming is evidenced by the fact that in Federal Fiscal Year 1983, 943 million federal dollars were earmarked to support this effort.

PRIVATE NONPROFIT REHABILITATION

The private nonprofit rehabilitation movement paralleled the development of welfare services in this country which began with private philanthropy and volunteerism. While there is evidence of rehabilitation programs being established during the 19th century, there were few in number; usually related to work programs; were church sponsored; and services were generally directed to the blind and the poor.

After the turn of the century, private community-sponsored rehabilitation programs became more in evidence but the major emphasis came after World War I and the passage of the first Vocational Rehabilitation Act in 1920. The real impetus was the establishment of the Office of Vocational Rehabilitation in 1943. Probably the most significant factor for the development of community rehabilitation facilities came as a result of the Vocational Rehabilitation Act of 1954 which contained specific provisions for direct funding of nonprofit facilities. Expansion

accelerated again when the Mental Retardation Facilities and Community Mental Health Centers Construction Act was passed in 1963.

Two specific types of facilities evolved; those which were medically oriented, providing physical therapy, speech, and related services; and the vocational programs which began as workshops and developed evaluation, work adjustment and placement services. These facilities were represented by two national organizations, the Association for Rehabilitation Centers (ARC) and the National Association for Sheltered Workshops and Homebound Programs (NASWHP).

As the two different types of centers began to grow and become more comprehensive, the distinction between them began to blur. This was epitomized to some degree by the merger of the two national organizations in 1970 into what is now known as the National Association of Rehabilitation Faciltities (NARF). NARF has chapters in many states and there have been further mergers with other organizations as residential programs, independent living and others becoming part of the rehabilitation spectrum.

During the 1960's, when the then two national facility organizations were in existence, they both recognized the need to develop standards and an independent accrediting body for their respective members. With the financial support of the federal government, they developed standards which were field tested. Their joint efforts, again with the support of federal funds, led to the creation of the Commission on Accreditation of Rehabilitation Facilities (CARF), covering both medical and vocational facilities. It was this cooperative venture which played a leading role in the final merger of these two organizations.

As stated previously, Public Law 565, passed in 1954, was a major contributing factor in the growth of the not-for-profit facility. Construction and staffing grants in addition to the articulation of services which could be best provided in such facilities brought about a close relationship between the state vocational rehabilitation agency and these community facilities. State agencies created facility sections; ongoing financial grants; and fee-for-service arrangements. The ensuing partnership between the public and private sector enhanced the quality of services available to disabled persons.

With the curtailment of federal programs and funding, the private not-for-profit agency began to look for new markets. It became obvious that disabled persons covered by the insurance industry were a meaningful source of new business. State legislation, increasing benefits, and no-fault insurance made rehabilitation a desirable cost-effective program. Quality services were available within the facilities, such as medical and vocational assessment, treatment, and placement. In addition, the case management role was also taken on by many community facilities.

PRIVATE PROPRIETARY REHABILITATION

Private proprietary rehabilitation had its beginnings in the 1940's with nurses providing rehabilitation services in Worker's Compensation cases. Liberty Mutual was a pioneer in this approach which emphasized a a medical rehabilitative model. Wausau Insurance Company was also a pioneer and was one of the first to employ rehabilitation professionals. They too hired nurses and their function, for the most part, was and is to reduce length of recovery, reduce permanent disability and to promote medical stability. In other words, the rehabilitation nurse, when

insurance companies first got involved with rehabilitation, were responsible for coordinating an early return to work with the patient, physicians, and employer. When the patient was not able to either return to his same job or a different or modified job with the same employer, that individual would usually be referred to a state rehabilitation agency to be rehabilitated in a new occupation. This approach was effective and served in keeping workers in the workplace during the World War II years. Private proprietary rehabilitation continued utilizing this model during the Post World War II years.

The next period of growth in private proprietary rehabilitation occurred during the 1960's. It was supported by the advent of increasing numbers of large claim payouts over a period of years. It was, at this time, that insurance companies began hiring rehabilitation consultants. During the late 1960's, several small companies began providing vocational services. In 1970, International Rehabilitation Associates (IRA) became the first national private-for-profit rehabilitation service provider with services directed primarily toward the injured worker.

The 1970's also began the period of rapid growth in the private proprietary rehabilitation. This growth has been fueled by expansion of benefits under Worker's Compensation laws. Additionally, private proprietary rehabilitations rapid expansion during the 1970's was facilitated by changes in laws and regulations in the public sector. Undoubtedly, another factor was that many state agencies concentrated on comprehensive services to the severely disabled and could not continue to aggressively seek out the injured worker for service.

In the Foreward of Vocational Rehabilitation of the Injured Worker (D. Lawrence and T. Hessellund, 1981), Dr. Porter attributes the sharp rise in vocational rehabilitation in the private sector to a combination of factors including:

1. Insurance carriers and private industry have realized the cost effectiveness of vocational rehabilitation.
2. Public agencies were mandated to give priority to individuals with limited vocational potential, i.e., the severely disabled and institutionalized populations.
3. Bureaucracy and inflexibility of public agencies.
4. The tendency of injured workers to resist the stigma of being associated with government welfare agencies.

IMPACT OF WORKER'S COMPENSATION

The origin of private rehabilitation and the expansion of the market for the services that private rehabilitationists provide have been closely aligned with the enactment and broadening of Worker's Compensation laws. From the enactment of the first Worker's Compensation Legislation in 1911, the system has broadened to the extent that each state now has Worker's Compensation legislation. In addition to state statutes, federal laws have been enacted to provide compensation coverage to longshoremen, harbor workers, federal employees and railroad workers.

Initially state compensation laws provided coverage for only accidental injury. However, coverage of workers has expanded to the point that all states have occupational disease coverage in one form or another. Generally, the overall trend in Worker's Compensation legislation has been toward expanding the scope of benefits extended and the dollar amount of the benefits. For example, Table I shows a ten fold increase

in medical benefits during the past twenty years. In addition, about 30 states currently have legislation to compensate the injured worker for reduced future earning capacity resulting from job related injury or disease.

TABLE I

Hospital and Medical Benefits Paid Under Workers' Compensation

(In Billions)

	State and Local	Federal	Total
Fiscal Year			
1960	$ .41	$ .01	$ .42
1965	.57	.01	.58
1966	.63	.01	.64
1967	.70	.01	.71
1968	.77	.02	.79
1969	.86	.02	.88
1970	.96	.02	.98
1971	1.06	.03	1.09
1972	1.16	.03	1.19
1973	1.32	.03	1.35
1974	1.57	.04	1.61
1975	1.82	.05	1.87
1976	2.14	.07	2.21
1977	2.49	.07	2.56
1978	2.86	.11	2.97
Calendar Year			
1978	2.9	.10	3.0
1979	3.4	.10	3.5
1980	3.8	.10	3.9

Sources: Social Security Administration, "Social Welfare Expenditures," Social Security Bulletin, various years, and Health Care Financing Administration, "National Health Expenditures," Health Care Financing Review, September 1981.

The expansion of rehabilitation services to the injured worker has enjoyed the encouragement of the Federal government. In 1970, the President established the National Commission on State Worker's Compensation Laws. He charged this Commission to assist states in providing adequate Worker's Compensation programs to accommodate injured workers. One of the recommendations offered by this Commission was for state enactment of mandatory rehabilitation provisions for injured workers. In January 1975, California became the first state to require the employer to provide mandatory rehabilitation as a part of its Worker's Compensation law. Today seven states have enacted legislation providing for varying forms of collecting large sums of money for the purchase of vocational rehabilitation services. In a free enterprise system, it is natural for private rehabilitation practitioners to move into this potential service market, which offers a reliable source of funding. Also, public rehabilitation has emphasized services to the developmentally or catastrophically disabled and has stressed comprehensive service provision. It has, therefore, often found its services not attractive to the insurance industry which emphasizes rapid return of the impaired worker to competetive employment, thus saving the carrier and policyholder money. With a different target population, private rehabilitation providers, both proprietary and nonprofit, have been effective in demonstrating their ability to design service programs to meet market needs. A market where the only expectation was returning the injured worker to preinjury economic status.

Economic Issues

It is not surprising that the cost of Worker's Compensation premiums

has increased proportionately to coverage expansion and benefit increases. For the year ending, December 31, 1980, U.S. employers paid $15,166,472,000 in Worker's Compensation premiums. Employers in California paid the largest amount for any state at $2,686,973,000. For the same time period nationally, $10,194,161,000 was paid to injured workers by insurance carriers for the costs of work related claims. Many of these claims remain open and therefore, payment in these cases will continue into the future.

PRIVATE PROPRIETARY REHABILITATION TODAY

The growth of private sector rehabilitation is dramatically illustrated by the fact that in 1970, private proprietary rehabilitation volume was estimated at $50,000 as compared to a volume of $450,000,000 in 1982 (LaFon, 1983). This figure does not include the business done by private nonprofit providers nor does it include the cost of in-house rehabilitation programs conducted by insurance carriers and the self-insured. When these two are considered, it is evident that private rehabilitation volume may well exceed the amount being spent for rehabilitation in the public sector.

There are currently (LaFon, 1983) in excess of 6,000 private proprietary rehabilitation professionals employed in the U.S. today including: Rehabilitation nurses, vocational rehabilitation counselors, job placement personnel, psychometrists, psychologists, vocational evaluators, occupational and physical therapists, supervisors and administrators. These personnel are employed by over one thousand private proprietary organizations.

Chapter II

Perceptions, Truths and Partial Truths

CHAPTER II

PERCEPTIONS, TRUTHS AND PARTIAL TRUTHS

A decade has passed in which proprietary rehabilitation has become an active participant in providing services to injured workers. Intensive growth occurred during this period of time, and perceptions concerning the activities and work done within the field led to many misconceptions. These misconceptions have created communication barriers. The committee members found themselves trying to separate "truth" from "myth" in order to effectively communicate with each other. This was not an easy task, both because individuals were often dealing with different sets of facts and because they had misconceptions about how others in the field behave.

Geography plays an important role in contributing to the confusion. It was found that knowledge based on one's experience in an individual jurisdictional area can rarely be generalized to the whole system. The State/Federal Rehabilitation Agency system may or may not be related to the Worker's Compensation system in any particular state. Even the legal system is plagued with the problem of differing meanings in various geographical areas as well as various jurisdictional areas.

> For example: According to the Analysis of Worker's Compensation Laws (1982), the loss of a thumb is worth $30,600 in Pennsylvania in 1983. This money is paid whether the individual is working or not. Yet, if the individual had been working for the Federal (F.E.C.A.) government while living in Pennsylvania, that same thumb would have resulted in a payment of $68,273. However, if the individual lived in Pennsylvania, but worked in New York State, the thumb is worth only $7,875.

Even understanding this factual information can be complicated. Some states pay temporary total benefits in addition to the specific loss payment while others deduct temporary disability payment from the scheduled injury amounts. Remuneration for specific loss leads many clients and outsiders to believe that they are always entitled to a lump sum payment for their injury in addition to medical coverage and wage replacement that were paid while they were recovering from the injury. It is a rude awakening for many to discover that this is not the case for many accidents or injuries. The problem is more involved than just misinformation, however. The practitioners themselves harbor beliefs as to how others are behaving within the field. These beliefs may be based on truth, half truth or myth. It is difficult to get beyond our emotional reactions and onto an objective review of the field until the basis for each other's perceptions is understood. Indeed, it is not entirely possible to do away with impressions that take on the validity of fact, which cannot really be substantiated.

The issue of perceptions, truths and partial truths is addressed by identifying a category of a problem and comparing and contrasting the internal perceptions of the three service providers: public, private nonprofit, and private proprietary. Obviously, there are many situations where the internal perception and the external perception are the same.

Our intent in this chapter is to clear the air. Consequently, a grid system was designed in an effort to create some reasonable way to look at these problem areas. An analysis was made to identify the major concerns and placed in this format to allow the reader an efficient way to review the perceptions that exist.

Category	State Agency, Private Non-Profit, Private Proprietary	Outsider's Perception One Individual's Truth Is Another Partial Truth or Myth
1. Personnel Selection	State Agency - meets state/federal hiring requirement. Civil Service rules often restrict selection based on degrees alone (EEO considerations).	Tradition bound - skeptical of going beyond own disciplines to hire.
	Private Non-Profit - personnel practices modeled after state agency practices.	Also tradition bound. Unwilling to take risk of hiring outside professionals.
	Private Proprietary - personnel selected on existing market expectations; i.e., ability to have expert status within the legal definition. More apt to hire based on degrees/certification.	Money oriented, not people oriented.
2. Philosophy Mandate	State Agency - Some agency workers still believe they are mandated to rehabilitate individuals to maximum potential. Return to competitive work, not sole outcome sought. (Homemaker and family worker closures, for example).	Habilitation focus; social service oriented; not results oriented. Serve primarily severely disabled.
	Status 00 to 26 designed to effectively track cases.	System inflexible, not adapted to meet different populations and needs.
	Private Non-Profit - meet the expectation of the referral source.	Try to manage diverse referrals in the same way. Throw MR's and injured workers together. Do-gooders.
	Private Proprietary - companies follow sound business practices in providing needed services. Return injured worker to preinjury economic status.	Insurance Company/Employer advocacy only. Does not provide comprehensive rehabilitation. (Short term vs. long term solutions).
3. Work Environment	State Agency - consider themselves capable professionals working within a stable work environment. Merit system and tenure provide environment for professional growth and practice professional rehabilitation skills.	Complacent, little incentive to change stifles creatively.
	Private Non-Profit - job security may be less if individual agency is unable to attract enough business. High professional self image. Low pay and benefits.	Attracts marginal rehabilitation professional dedication instead of money.
	Private Proprietary - follow the entrepreneurial model, one in which capable individuals will excel.	Use/abuse counselors and then fire them; follow unethical practices to gain referrals. High turnover and burnout rate.

4. Service Orientation	State Agency - process-orientation is necessary due to the severity of the employment handicaps experienced by clients with little or no work history. Extensive services may require extensive time (thus costly) for determining feasibility of vocational outcome. Maximum potential may never include competitive employment. Meeting legislative mandates.	Insurance industries see as too slow, not responsive to employers' needs. Apathetic large caseloads lead to sending excessive numbers of clients to training or schooling that is not necessary or productive. Vague and idealistic. Goals result inappropriate expenditures.
	Private Non-Profit - have developed facilities in order to aid the above process by offering evaluations and other necessary services. Some agencies are developing services for other third party payers due to the decrease in state agency monies. Are finding it a challenge to meet these new demands.	Bricks and mortar - expensive to maintain - trying to shift gears in order to stay in business. Offering same services such as extensive in-house evaluations whether needed or not. Don't understand market, dependent on state program.
	Private Proprietary - product orientation due to the nature of the referrals, need to be cost effective. Individuals served usually have work history and capacity to return to competitive employment. Due to financial disincentives to return to work, cases must be worked in a timely manner in order to return the individual to work before disability and dependence becomes a lifestyle.	Cream easy cases in order to look good to insurance adjusters. Flash vs. realistic outcome. Wants best of state agency evaluations, tax credit, and new product development. Exploits state agency. Expedites job placement at expense or long term solutions.
5. Staff and Their Knowledge Base	State Agency - have broad knowledge about disability and its total impact on individual. Consider themselves competent to handle all disabilities. Are uneasy with legal and insurance issues.	Poorly trained in insurance cases. Lack legal and fiscal knowledge necessary to handle these cases. Lack knowledge of labor market.
	Private Non-Profit - routinely handle state referrals. Developed expertise in providing those services such as evaluation, testing, work adjustment needed by state agencies.	Same as above. "Do-Gooder" attitude.
	Private Proprietary - having specialized in the injured worker cases, consider themselves experts in the legal and insurance aspects. Use personnel from various disciplines, this cross fertilization has strengthened each other's knowledge.	Knowledge about the world of work. Good intentions. Under trained in all aspects of rehabilitation. Lack standards. Not interested in what's best for clients.

6. Incentives	State Agency - personnel laws and merit system allow personnel to work without the pressures of outside interference. Are paid on annual salary. Private Non-Profit - most pay annual salaries with a system of merit increases. A few are experimenting with a bonus system. Generally low pay. Private Proprietary - uses various bonuses including money to encourage personnel. Same system that is used in the business world.	No incentive to move cases quickly; therefore, they do not. No accountability or rewards for outcomes.* Case outcomes can be bought. *Bonus systems have personnel dealing in quantity rather than quality of services.
7. Service Fees	State Agency - state/federal budget allotments determine available monies. States negotiate contracts with service organizations and workshops. Private Non-Profit - are able to offer fee for service to state agency and other third party payers. Private Proprietary - consider it standard business practice to establish a fair market fee for a given service. Discounts for bulk accounts are common.	Monopoly - led to low fees. Unfair market edge in Workmen's Compensation cases. Will accept whatever state agency and other contractors will pay. Unethical price fixing going on; offer discounts; make money off the disabled.
8. Marketing	Public - not a generally understood or accepted concept for state. Private Non-Profit - usually have marketing efforts, but budgets are small and efforts minimal. Private Proprietary - marketing is of prime importance, may involve considerable expense.	Losing out to the private companies who know how to accomplish it. Unfair cost advantage. Females used to gain an unfair competitive marketing edge to obtain cases. Profit motive can lead to unethical business practices.

9. Advocacy	State Agency - concern for the rights of the disabled. Counselors become a client advocate to gain benefits from other systems. Private Non-Profit - heavily involved in client advocacy to specific disability groups to gain benefits and services from all systems. Private Proprietary - neutral third party approach. Counselors deal with various parties involved in a situation in a neutral factual manner.	Professional conflicts over court appearances. Advocates on basis of emotion not fact. Confusion with a close up typical referral. Will appear in court for either side for a fee. No other concern for advocacy.

PERCEPTION

Some mention should be made about two primary referral sources for the private-proprietary providers. These are the insurance companies and self-insured employers whose interest lies in expediting rehabilitation of those for whom they have liability. Their organizations are typically viewed by those concerned about the disabled as having no interest in the individual claimant. They are seen, rather as necessary institutions seeking assistance in obtaining fast results regardless of the claimant's condition and bringing constant pressure on service providers for quick turnover of files. There is a general impression among rehabilitation professionals (particularly in the public sector) that insurance claim persons employed by either the insurance company or self-insured employer are not knowledgeable of the rehabilitation process. Also, many are convinced that their rehabilitation nurses are trying to handle all aspects of cases, with only the companies best interest in mind. Self-insured employers and insurance companies tend to have a common conviction that the state rehabilitation agency lacks the orientation and interest in providing the scope of services they require in a timely manner.

CONCLUSION

The previous tables should be viewed as an opportunity to look at how others perceive us in our various professional roles. Due to the similarity of many of the terms used to express our philosophy and behaviors underlying the service delivery model of public, private proprietary and private nonprofits; the reader is cautioned against assuming that there is not specific uniqueness and differences that can impact

on them. It is not uncommon to find professionals seeking employment in the private sector after many years of public and nonprofit work. There is also a significant number of workers in private proprietary work who later choose to seek employment in the public or nonprofit sector. The areas of similarity as well as the differences have created the need for this Institute on Rehabilitation Issues document. We wish to treat this topic in an open and honest manner. It is hoped that we can dispel some of the misconceptions held toward each other and address the issues. It is hoped that the following chapters can be used to provide a basis for addressing these issues with the injured worker. The purpose is to learn how cooperation can be achieved and to learn from each other.

Chapter III

Proprietary Rehabilitation Described

CHAPTER III

PROPRIETARY REHABILITATION DESCRIBED

PROPRIETARY REHABILITATION PROVIDERS

The majority of the rehabilitation business done by the private sector is done by proprietary companies. These companies exist in several forms and all have one thing in common, they attempt to make a profit.

Sole-Proprietorship

The most basic form of employment in the private sector is a single person sole-proprietorship wherein a single professional works by himself in providing services. Many of these sole-proprietors begin by working part-time for themselves while maintaining full-time employment in another setting such as a state agency. Before normal business expenses such as liability insurance, typing services, accounting services, legal services, printing and office supplies, transportation, phone, answering services, and office rent, a sole-proprietor should generate a pre-tax income of $20,000 to $80,000. This employment setting is appropriate for those who are self-starters, highly organized, and who can work relatively alone without the fraternization, professional stimulation and socialization found in a larger work setting. Training opportunities are limited.

Small Businesses

The next larger form of a proprietary business enterprise can be classified as a small business. Any business in the field of rehabilitation grossing less than $1,000,000 a year is a small business. There

are several hundred of these throughout the country. The largest concentration of small rehabilitation firms are found in California, Minnesota, Michigan, Pennsylvania, Florida and Georgia. They take the form of sole-proprietorships with several employees, partnerships with two or more partners, or corporations. For purposes of limiting liability and maximizing tax advantages, the corporation is probably the business form of preference. These small businesses may have from two to fifty professionals working for them. Some retain professionals as "employees" with employee benefits such as insurance, vacations, sick pay, and paid holidays. Others retain professionals on "employment contracts" wherein the professional is actually an "independent contractor" rather than an employee. There are merits to both systems.

There are considerable differences between and among these small businesses in their pay scales, benefits, training programs, opportunities for advancement, productivity requirements, office arrangements, and service models.

Small businesses offer employment in a variety of occupations including counseling, nursing, job development, supervision, management, sales and training. Income varies from one occupation to another and depends upon many factors such as work experience, education, geographical areas, and size of employer.

Some businesses may require an employee or contractee to sign a noncompetition agreement. The professional employee agrees that they will not compete with their immediate past-employer for a specific period of time. These contracts specify either a length of time, usually at least a year, or a specific geographical area, usually at least 100 miles.

Large Businesses

All of the preceding information on small businesses apply to large rehabilitation providers. There are over twenty of these firms in the country ranging in size from slightly over $1,000,000 annual volume to over $40,000,000 annual volume. Generally speaking, the larger the business the more formalized are the policies on salary and performance review, training, promotion, work rules, benefits, and service delivery.

MARKETING

There must always be a way to distribute a product or service to its user. For our purposes, we will label this distribution process as "marketing." Marketing entails many activities, among which are sales and advertising. Within the private sector "sales" and "marketing" are often used interchangeably.

Sales

The most common method used to market private sector rehabilitation services is direct person to person sales. In all of the small businesses and in many larger ones, this is done by professional rehabilitation personnel as an adjunct to their case work. This method of sales is utilized for two reasons. First it is often less expensive than hiring a person for sales work only and secondly, as a market matures the referral sources get to a point where they don't want to see "salespeople." They want to meet and interact with the caseworkers.

The second method of selling is by using a professional sales staff. These sales personnel may be rehabilitation personnel, insurance personnel or people with a sales background.

Regardless of the type of sales personnel utilized, they all function

more or less in the same fashion. They make in-person presentations to referral sources and attempt to get the referral source to utilize their organization's services. As any geographical market matures, selling in that market becomes proportionally more difficult. In some markets selling has now progressed to the second level, making calls on indirect referral sources such as doctors, attorneys, employers and unions.

Advertising

Most private sectors also use one form or another of advertising. The most basic form of which are sales brochures and the most sophisticated of which are TV and radio commercials. The use of advertising by rehabilitation is still somewhat embryonic but is emerging at a rapid pace.

REHABILITATION PRACTITIONERS

Rehabilitation specialists that become involved in a case involving Worker's Compensation insurance will find themselves working with a variety of people not normally part of the rehabilitation community. They will be in contact with insurance people, attorneys, members of administrative bodies, and perhaps other state and federal officials. The rehabilitation specialist must understand how these various people interface with each other and with them. Each person involved has their own particular interest in a case, and often these interests create adversary situations. Rehabilitation specialist often find themselves in the middle of these situations. Often they are called upon to testify in these cases. Consequently, they need to develop skills in presenting case findings in these situations.

Disabled people often retain lawyers or attorneys to represent them

in insurance cases. Attorneys may or may not cooperate with the rehabilitation specialist in regards to rehabilitation. When they do not it can be frustrating for an anxious and dedicated rehabilitation specialist. Worker's Compensation laws and similar laws are designed to be self-administering in order to expedite decision making. This does not always happen, however, and rehabilitation specialists have to learn patience when working in the legal arena.

Rehabilitation Nurses

Rehabilitation nurses may have either a two year Associate of Arts degree, a three year diploma, a B.S., or M.S. RN's are usually licensed in the state in which they reside or in which they are principally employed. Prior to entering the field of rehabilitation they generally have extensive experience in: Critical care or extended care rehabilitation facilities; extensive hospital experience; or industrial or public health nurse experience. They generally perform medical care assessments, medical care coordination, coordinate return to work with pre-injury employer and in some instance may perform job-placement. Depending upon the employer, they may act as a client advocate - seeing that the client receives proper and timely services. They may also be responsible for assuring that the case moves along at an appropriate pace.

Rehabilitation Counselors

The counselor frequently has a Masters degree in rehabilitation counseling, but may have a lesser degree or different social science degree. Commonly they are Certified Rehabilitation Counselors (CRC) and depending upon the jurisdiction may be registered, approved, or licensed. The counselor may or may not have had previous work experience as a rehabilitation counselor before working in the private sector. They most

often engage in vocational exploration, plan development, job seeking skills training, and placement. They also, depending upon employer and jurisdiction, do testing, medical care coordination, vocational evaluation, and may testify in court or an administrative hearing.

Placement Specialists

These professionals come from a wide variety of educational backgrounds. Most have at least a Bachelors degree and some have Masters degrees in placement. There is no particular certification or licensure as a rehabilitation placement professional although many are certified as counselors or evaluators, or licensed as counselors or nurses. They come from a wide variety of work experiences, from sales and employment agencies to counseling or teaching. They principally do job-development but many also engage in vocational exploration, job seeking skills training, school research, labor market surveys, on-the-job training development, placement follow-up, and run job clubs.

Ancillary Health Care Professionals

There are many other health care professionals that deliver rehabilitation services. Among which are physicians, psychologists, vocational evaluators, occupational and physical therapists and others. The composition of the "rehabilitation team" will vary from case to case.

SERVICES PROVIDED

Medical Coordination

One of the primary responsibilities of rehabilitation nurses is medical management. They try to get involved early in the case to evaluate the physical and the medical care the injured person is receiving. At times, nurses may try to steer the injured person to the best treating

physician or, in catastrophic cases, to specialized medical facilities such as spinal cord units, burn units, and amputation clinics.

Many physicians are not involved in the medical or vocational rehabilitation aspects of treatment. The rehabilitation nurse is often influential in making certain that injured persons are referred for rehabilitation with the right physician at the proper time.

Vocational Assessment

The vocational rehabilitation counselor gathers diagnostic information from several sources. The purpose of a vocational assessment is to get a clear picture of the client's current vocational strengths, weaknesses and potential use of transferable skills. Techniques used routinely include: application blank information; review of medical information particularly and physical limitations; and a complete diagnostic interview emphasizing vocational skills and experience. Often these interviews will last several hours. Lesser used techniques include: psychometric testing; individual diagnostic testing; selected job samples; complete vocational evaluation; and work tryouts.

Job Analysis/Job Modification

Job analysis is a systematic study of what the worker actually does and a breakdown of a particular job into its component parts or tasks (U.S. Department of Labor, 1972). The information gained is used in conjunction with the client's vocational assessment data to determine if they can function on that particular job.

If the worker can not function on a particular job, as it is constituted, job modification may be attempted. It may be that the person can complete all but one of the required tasks in which case this task might be assigned to another worker. In other cases a machine may be modified, a special tool provided, a work space modified, or a procedure changed.

Labor Market Research

Labor market research involves the gathering of data about the type and number of jobs in a geographic location. State Department of Labor information may be used along with data from want ads, contacts with personnel departments and others. The information gathered is used in legal testimony for plan development, and in vocational counseling.

Job Seeking Skills Training

Many individuals have not sought work for significant periods of time. Consequently, they have difficulty conducting a job search. Job seeking skills training takes many forms from informal counseling, to formal behavioral management and formal lecture/practice classes.

Job seeking skills typically covers: completion of application blanks; interviewing skills; where to seek jobs; appropriate dress and hygiene; how to organize your time effectively; how to present your skills; and how to answer difficult questions. Training periods vary from a few hours to several days. Most often the training is done in small groups.

Job Development/Placement

To expedite job placement, a job developer may telephone or talk to potential employers for a client. The client is then required to follow-up on-the-job leads developed. Depending upon the situation, the job developer or counselor may also accompany the client to the actual job interview.

PROGRAM EVALUATION

There are various criteria used in measuring the effectiveness of rehabilitation services. These measures are most often used by regulatory

agencies such as the State Worker's Compensation Department or by referral sources.

One overall requirement is some form of resolution to the case. The resolution or reason for closure should be definitive and documented. Following are some criteria used for evaluating case services.

Cost: What was the total case cost? Not only the cost of the rehabilitation provider's services but cost of temporary disability payments during rehabilitation, books, tuition, etc. are counted in the total case cost.

Length of Time Case Open: How long was the case open from date of referral to date of closure? When temporary disability is paid during rehabilitation, this benefit cost often continues until final case resolution and consequently adds significantly to the total case cost.

Documentation: Are the rehabilitation provider's reports clear, readable, and useable? Do they explain all of what is going on? Will they stand up as evidence in litigation? Are reports timely?

Service Attitude: Does the service provider have a "service attitude?" Does he or she understand the needs of the referral source and make every effort to meet them?

Rehabilitation Results: How many clients are returned to work? Did the plan work? Was the case settled?

Case Resolution: Did the services provided have a positive or negative effect upon case resolution, e.g., settlement, percentage of disability, exposure for future loss of earning?

SERVICE DELIVERY METHOD

The vocational rehabilitation model used in private proprietary

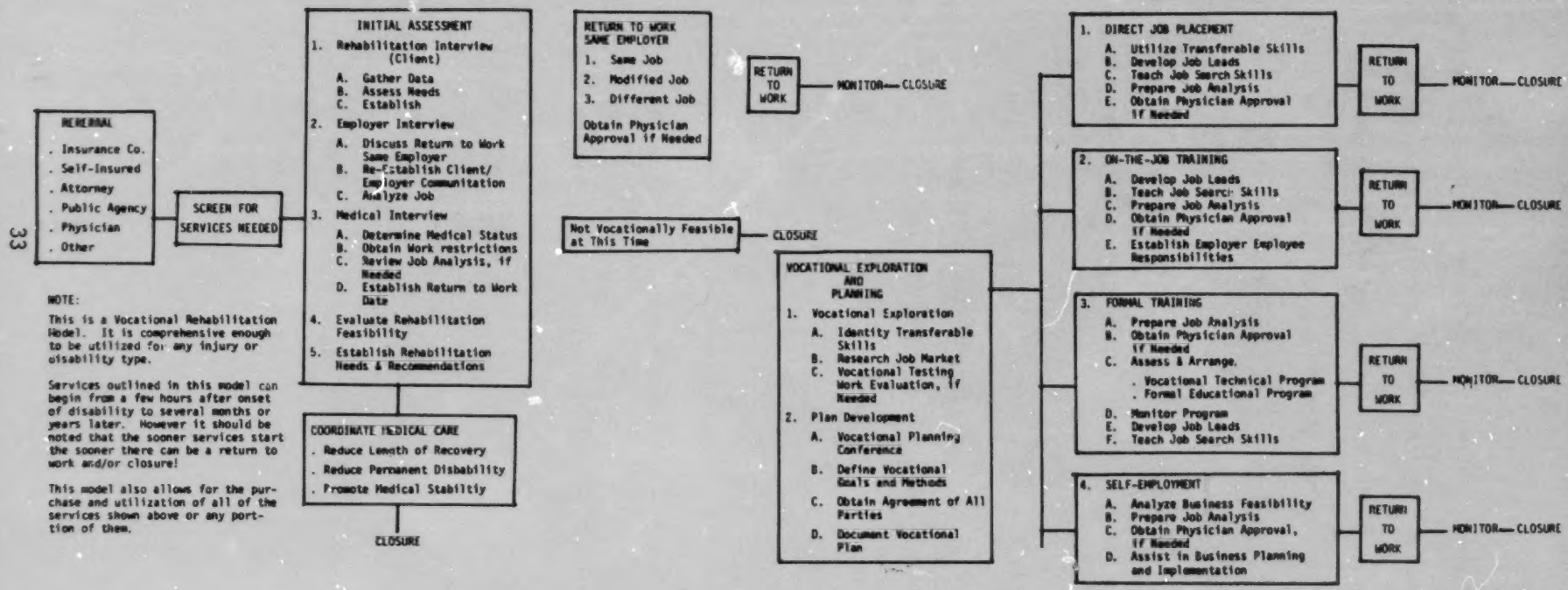
rehabilitation takes much of its structure from the traditional model. The impression many referral resources have is that the traditional model used by the public agency emphasizes training (train-place approach); while private proprietary sector places emphasis on placement utilizing interests, skills and aptitudes (place-train approach). See Figure 1. Whatever the truth of this impression, the primary goal of the private proprietary professional in all cases is the successful return to work of injured workers within the framework of the law.

Referral and Initial Assessment

The provider first receives a referral. In most instances the clients receiving services do not seek them on their own. They are referred to a rehabilitation practitioner by an insurance company, self-insured company, attorney, public agency, or physician. Before services begin, the file is generally screened to assess the needs. If it is determined that the client does not need or cannot benefit from rehabilitation at that time, it is the private practitioner's responsibility to let the referral agent have that information. If a service provider does not deal with the referral sources in an honest manner, referrals will be few and far between.

After the case has been referred and the client has agreed to participate, the next step is an initial assessment. The initial assessment phase includes gathering information from a variety of sources in order to establish rehabilitation feasibility and a tentative plan to move the case forward. These steps include: (1) A comprehensive interview with the client to take a medical, financial, social, educational and vocational history and to establish rapport (often lasting several hours); (2) Review medical reports generated by the hospital, treating

Figure 1.



NOTE:

This is a Vocational Rehabilitation Model. It is comprehensive enough to be utilized for any injury or disability type.

Services outlined in this model can begin from a few hours after onset of disability to several months or years later. However it should be noted that the sooner services start the sooner there can be a return to work and/or closure!

This model also allows for the purchase and utilization of all of the services shown above or any portion of them.

physician and/or information from an independent medical examination. Often review of medical information will include a personal or phone discussion with the physician; (3) An interview with the employer to re-establish communications and discuss return to work; and (4) Analysis of the job if necessary. The earlier the referral is made to a rehabilitation provider the greater the chance that the worker will return to the same employer. The employer will lose interest and motivation to return the injured worker to employment if communication is delayed for a long period of time. Minnesota, for example, mandates a referral at 30 days post-lost-time injury for back cases and 60 days for other injuries for vocational-medical assessment and a contact with the employer. This early intervention and high priority should expedite the worker's chance of returning to work.

Priority System

The proprietary rehabilitation provider often uses a priority system. The priority system usually involved the following sequential steps:

1. Return the injured worker to the same employer at the same job or the same job with modifications.
2. Return the injured worker to the same employer in a different job.
3. Find a new employer, new job utilizing past skills and abilities within the physical restrictions. This step is generally referred to as direct job placement.
4. Develop on-the-job training programs for the injured worker.
5. Develop a program involving formal training.
6. Set the injured worker up in self-employment.

Evaluation, Vocational Exploration, Planning and Placement

After the initial assessment stage of the process, the case can take several directions. If it is determined that permanent work restrictions

preclude the individual from doing the job he was doing at the time of injury, the case moves into vocational exploration, vocational evaluation, vocational planning and return to employment. This step is very significant and is the point when client participation becomes essential if return to work is to be achieved. The client has to understand that his involvement and cooperation is crucial to the outcome. In fact, it is their obligation under Worker's Compensation law. During this phase appropriate alternate job goals may be identified through interest testing, performance-based testing (work sampling), and aptitude testing as well as labor market surveying to determine job availability. Psychological screening as well as vocational physical capacity evaluation are also done during this phase of the process, if needed.

Direct job placement is the part of service delivery model that gets most attention when discussing rehabilitation service delivery in proprietary rehabilitation firms. Placing the injured worker back in the work force without the expense of formal retraining is what sells private rehabilitation service. The information the injured workers learned about themselves, in-concert with the new job seeking skills and job leads that were given by the rehabilitionist, will provide the tools necessary for successful direct job placement. The rehabilitation specialist must perform detailed job analysis if physician approval is necessary prior to placement.

On-the-Job Training

If direct placement cannot be achieved, on-the-job training agreements are sought with willing employers. The objective is to give the employer an incentive to train an employee on-the-job by subsidizing or replacing the salary during the training. This can be done by utilizing

the client's weekly temporary total benefit in lieu of salary. Many times the carriers would be willing to send temporary total checks directly to the new employer. The employer, during the training period, pays the worker utilizing these funds. It is important that the program be structured so that the employer feels a real commitment to training the individual. In addition, the worker will feel involved and have a job with the new employer if the competencies set out in the original agreement are mastered. Such on-the-job trainings have proven to be very effective in returning injured workers to work because the training is directly related to a specific job. However, careful attention must be paid to state and federal wage and hour laws regarding on-the-job training. As an alternative, formal training may be coupled with on-the-job training to accelerate the training and make the employee productive at an earlier date.

Vocational Training

There are times when vocational training is required to achieve rehabilitation or return to work. The training program must be result oriented. Consequently, a labor market survey should be done to demonstrate job availability upon completion. The program is monitored monthly by the rehabilitation professional and job placement begins upon completion. Training should be as short in duration as possible and undertaken with close attention and supervision of the rehabilitation specialist.

Self-Employment

The last item on the priority list is self employment. In some instances it is the quickest most feasible method of returning someone to competitive employment. However, it is generally considered to be the

last resort. This works best when a hobby has been developed to a point just short of a business. The rehabilitation consultant, along with the client conduct a market survey to ascertain a market for the business, and then develops the plan to expand it into a profit-making enterprise. The client must demonstrate expertise and the willingness and ability to follow through and carry the responsibility for running a business. Small business ventures have a high rate of failure, especially in our current economy and consequently are used sparingly and only after careful assessment and planning.

SUMMARY

The above paragraphs give a very simple overview of the private proprietary rehabilitation service delivery method. It is important to realize that to be successful the professional must be flexible. A rigid approach is for the most part not productive. Every client going through the rehabilitation process is unique and the method in which they are dealt with should also be unique. The rehabilitation professional must however adapt practices to fit within the framework of the Worker's Compensation laws in each jurisdiction in which rehabilitation provider operates. Many times state statues and corresponding promulgated rules control the method and scope of service delivery. It is also imperative that the client be responsive and cooperative to achieve these results. If the client is referred early in his own rehabilitation process, being responsive and cooperative on his behalf will not be difficult.

Chapter IV

The Marketplace

CHAPTER IV

THE MARKETPLACE

According to the Urban Institute Study (1981), the insurance industry is currently the largest third party payer of private rehabilitation services. It is a result orientated business where employees are expected to handle a large number of cases with rapid turnover. Claims personnel seek rehabilitation companies that will aid them in accomplishing this goal. The emphasis is on prompt contact and job placement. Usually, long-term educational or training programs are not compatible with these goals.

The flexibility of the proprietary rehabilitation provider model serves the insurance industry well. An insurer's duties to a claimant are usually clearly defined either by the insurance policies or by the government vis-a-vis legislation, adminstrative rules and regulation, or case law. Although an insurers responsibility to a claimant differ from one type of policy to another and from one jurisdiction to another, there is one common thread. The responsibility of an insurer is to assist a claimant in returning as closely as possible to their preinjury medical, or depending upon the coverage, vocational condition. In no instance does the insurer have a responsibility to help improve the claimant beyond his or her preinjury condition.

FEDERAL PROGRAMS

There are three significant programs provided by the Federal Government: the Longshoremen and Harbor Worker's Act, the Federal employees

Compensation Act, and the Railroad Retirement/Employer's Liability Act. Each provide markets for private proprietary rehabilitation providers.

Longshoremen and Harbor Worker's Act

This is a Federal Worker's Compensation law applying to persons working on any navigable water - river, lake, bayou, bay, gulf, ocean, and also "any adjoining pier, wharf, dry dock, terminal, or building." This law, enacted in 1927, was designed to cover a class of maritime workers in certain situations that had not been covered prior to that time. The law is very liberally interpreted for the benefit of workers injured near navigable waters. While this is a national law, it operates mainly in port areas.

Disputes are resolved before an Administrative Law Judge. Once this judge issues an award or decision, either party has 30 days to appeal, otherwise the decision is final. There are district offices under the jurisdiction of the Office of Worker's Compensation Programs in Washington, DC, that are responsible for carrying out the Law Judge's orders. Appeals, however, may be made to a benefit review board, which is an independent quasi-judicial body consisting of three members appointed by the Secretary of Labor. The review board conducts its own hearings and renders a decision based on their findings. Decisions of this Board may be appealed to the United States Court of Appeals. In turn, the U.S. Court of Appeals can affirm, modify, or reverse any order of the Board. An appeal from the U.S. Court of Appeals goes to the United States Supreme Court.

The law provides for unlimited medical coverage with high weekly benefit rates. Employers can either self-insure and pay the benefits themselves or carry insurance through a private company.

Federal Employees Compensation Act

This law protects employees of the United States Government who suffer injuries or illnesses while in the course of their employment. It is a national law and applies to all employees of the United States Government, no matter where they may be located, who are injured in the course of their employment. The law is administered by the Secretary of Labor who in turn is authorized to delegate to any officer or employee of the Department of Labor any of the powers conferred by the Act. Benefits for disability and medical expense are paid out of an Employee's Compensation Fund that is established in the Treasury. The Secretary of Labor submits to the Bureau of Budget annual estimates for appropriations necessary to maintain this fund. The Secretary usually delegates the administration of this law to a commission, which makes the necessary rules and regulations for the enforcement of the Act and decides all disputes arising out of the Act. Appeals from a decision by the commission must go to an appeal board that has the power to hold hearings, gather information, and to make independent decisions. This is a very liberal law with high benefits and unlimited medical expense coverage. Rehabilitation benefits are included under the medical expense provision.

The Federal Government does not have an investigative branch connected with the administration of this law. Most of the information necessary to make a decision on compensability is gathered by management personnel. This results in a liberal interpretation of the Act and benefits are easily accessible to most employees.

Railroad Retirement/Employer's Liability Act

The Railroad Retirement Act was established for the benefit of railroad employees who are injured while employed by any railroad. It

includes coverage for disability benefits and payments of medical expense. Disability payments commence immediately upon proof of disability. Usually medical information from an attending physician is sufficient to meet this requirement. Benefits are payable for life and are not subject to federal income tax. Under this Act, disability has a two-fold meaning: "permanent disability - permanent physical or mental condition that prevents the individual from engaging in any regular employment; occupational disability - a permanent physical or mental condition that prevents the individual from engaging in his or her own regular employment."

This Act is administered by a board composed of three members appointed by the President. Each member serves a five-year term. The board establishes rules and regulations and adjusts all disputes. Appeals from the board's decisions go to the Federal District Court. This Act is not to be confused with the Employer's Liability Act which also applies to employees of the railroad and is based on negligence. The employee, in order to collect, must prove that their injury was the result of some negligent act of the employer, the railroad. While the Railroad Retirement Act does not require negligence per se, it requires an injury to a railroad employee that occurred while in the performance of their duty.

STATE PROGRAMS

Worker's Compensation Laws

State Worker's Compensation laws were developed early in the 20th century to cover injured employees who were disabled because of an occupational traumatic event. Worker's Compensation was designed to be a

self-administering law where the benfits would be easily available to an injured employee without the necessity of legal action. Unfortunately, in most states, such is not the case. The intent was to provide the disabled worker with prompt weekly benefits and adequate medical attention to speed their recovery so that they could return to work as soon as possible.

Prior to the passing of this law, workers had to proceed against their employer in a court of law in order to collect. In other words, they had to prove their injury was the result of a negligent act of the employer. This required that employees prove an injury was caused by something the empoyer did or failed to do. As can be imagined, negligence was difficult to prove and was very time-consuming. The employees often found themselves destitute by the time the case was scheduled for trial.

Under Worker's Compensation laws, the employee gives up the right to proceed against the employer under negligence (tort) in return for prompt payment of benefits. These laws were designed to reduce litigation. However, in many states the process has become more complex and still requires multiple hearings before decisions are made.

In a few states, the Worker's Compensation laws are administered by the courts. However, in a majority of states administration of Worker's Compensation laws is vested in a commission or board composed of three to five members appointed by the Governor. These boards are referred to as an industrial commission, a Worker's Compensation board, or by some other similar title. In addition to their administrative duties, the boards or commissions, with few exceptions, have the authority to make decisions on disputes between parties. They are, in this respect, a

quasi-judicial body. The commissions or boards appoint referees, judges, or examiners, to conduct hearings in order to obtain facts on disputes between parties and to issue awards. The boards' judicial duties are confined to hearing appeals that come from the referees' or judges' decisions.

Two Worker's Compensation Systems

There are basically two systems in effect today in the United States, a direct payment system and an agreement system. Under the direct payment system, the employer notifies their insurance companies of an injury to one of their employees. The insurance carrier has the opportunity to investigate the facts surrounding the injury if they so desire. If not, the employer in the case of self-insurance or the insurance carrier, on behalf of the employer, assumes the payment of benefits. A hearing in front of a referee or judge is not required. Medical expense and disability benefits are paid by the employer or carrier without entering into any form of written agreement to do so. Only cases which are disputed are submitted to a referee or judge for decision.

The agreement system requires the employee and the employer or the insurance carrier on behalf of the employer, to enter into a written agreement. They have the opportunity to first investigate the facts of injury prior to any agreement. Under an agreement, the employer promises to pay compensation and medical benefits, and the employee agrees to accept these offered benefits before any payments commence. The written agreement is filed with the industrial commission or board and is binding on both parties. As a general rule, the carrier may not later deny compensation or any other part of the claim. This is true even if it later should determine that the claim is not compensable. This type of system

usually is slower than that of the direct system and requires a more detailed comprehensive investigation of the facts before payments commence.

Second Injury Fund

One important feature of the Worker's Compensation law is the provision known as the Second Injury Fund or Subsequent Injury Fund. The law recognizes that many unemployed handicapped workers can make significant contributions to the business community. Second Injury Funds were developed to reduce employer liability for a preexisting injury so as to aid reemployment. They are designed to meet problems that occur when an injury and a preexisting condition combine to produce a disability greater than that caused by the injury alone. The Fund encourages hiring of the physically handicapped and more equitable allocates costs of providing benefits to the disability caused by the injury alone, even though the employee receives a benefit related to his combined disability. The additional payment to the employee because of the preexisting disability is paid by the Second Injury Fund. Some states such as Minnesota and Michigan require that the injured person have their preexisting disabilities certified with the state prior to the employment. Employers can only obtain benefit from the Second Injury Fund when they knowingly hire a person with a preexisting disability. These funds are supported by premium taxes and assessments on Worker's Compensation payments. The provisions of these funds vary considerably by state.

Self-Insurance

Employers have several choices, they can either purchase their compensation coverage through an insurance company, a state fund, or become self-insured. Some larger employers prefer to directly assume the

responsibility for the Worker's Compensation insurance coverage by self-insuring. In addition, smaller companies in some states may pool their risks and liabilities through group self-insurance. These options are available to qualified employers who meet specific requirements in most states in lieu of obtaining such coverage through state or private insurance carriers. They must post a bond or in some other manner prove that they are financially able to pay any claim that might be filed against them.

The primary reasons given for self-insurance are to reduce administrative costs, to maintain control of reserve funds for projected liabilities, and to retain the interest earned from these funds. Some firms are not large enough to support a self-insurance plan. For self-insurance to be feasible, a firm must be large enough to be able to predict its own losses. It is this function of the "law of large numbers" which supports a self-insurance plan. Until that level of predictability is reached the company will purchase a policy from an insurance carrier.

Self-insured employers are bound by the same laws, rules and regulations as an insurance carrier. Consequently, they must provide the same coverage and services as would be required of insurance carriers under their respective jurisdictional laws.

State Insurance Fund

Some states require all employers to carry their Worker's Compensation coverage through the State Fund. Other states have developed State Insurance Funds providing employers with Worker's Compensation insurance as an alternative form of coverage or as an insurer of last resort. These funds are state-managed entities in open direct competition with private insurance companies. They are usually managed by commissioners who in

turn appoint an executive director responsible for the direction and operation of the fund. These funds act very similar to an insurance carrier and are subject to all the laws and benefit provisions to which any private insurance company may be subjected.

Worker's Compensation Rehabilitation Provisions

All states have some form of vocational rehabilitation provision found in their Worker's Compensation Act. Some states, such as California, Minnesota, Michigan and Florida are very comprehensive and they require mandatory vocational rehabilitation for all employees falling within certain specifications. Once an employee meets the requirements, a rehabilitation plan for getting this injured employee back to work must be developed and submitted to the Industrial Commission. The injured employee, the employer, and the insurance carrier must agree before the employee undertakes the plan. In case of disputes regarding the plan, hearings are held to resolve the issues.

In other states, it is not mandatory to submit a return to work plan for disabled employees. Some of these states limit rehabilitation to payment of a small weekly maintenance benefit. Each state law requires close examination to see just what benefits are provided under the rehabilitation statute. States that provide benefits based on loss of wages or loss of wage-earning capacity usually are most involved in vocational rehabilitation because return to work is usually necessary before benefits cease.

OTHER INSURANCE

No-Fault Automobile Insurance (Personal Injury Protection)

No-fault automobile insurance is found in 26 states. It is based

on a concept that the insured person, as defined by the automobile policy, will receive certain benefits for disability arising from an automobile accident regardless of who was at fault in the accident. Thus, the term no-fault automobile insurance. A wide range of benefits are available. In some states, there is a specific limit, a "CAP" on both disability benefits and medical benefits. In a few states, there is no limit on medical expense or rehabilitation, but there are limits on the disability provision. Under most no-fault laws, rehabilitation has not been specifically defined, so there still remains conflict as to whether benefits are limited to physical rehabilitation with the exclusion of vocational rehabilitation. However, in a few states, vocational rehabilitation is a specified covered benefit. The insurance industry has provided vocational rehabilitation benefits in states that do not specifically include it in the statute. In severe injury cases, returning the disabled person to work oftentimes reduces medical expense and the length of disability thereby reducing costs.

No-fault automobile insurance is a relatively new law. In 1978, the insurance industry conducted a study to determine exposure they had for severly injured persons in states without limits on medical benefits or rehabilitation. An All Industry Research Advisory Council (1979) undertook a study of serious personal injury claims with ultimate payout exceeding $100,000 per case. These states have unlimited medical and rehabilitation benefits. Two years later (Pip, 1982), a follow-up survey was conducted which revealed that: (1) of the 420 injured persons 15 had died, 56 had returned to work, 229 were unemployed due to their automobile accident, (2) 91 were unemployed not due to the accident, and (3) a valid response could not be obtained from the balance.

From a cost standpoint, the average expected payments of those who had returned to work equalled $181,400, as compared to $426,100 for those persons unemployed due to the accident. At the time of the original survey, only 12% had received vocational rehabilitation, as compared with 30% in the follow-up survey. This supports the proposition that a person who returns to work will require considerably less medical attention over the life of the claim than a person who remains disabled and unemployed. Of the cases studied, 50% involved brain injuries, 40% spinal cord injuries, and the balance, had multiple serious injuries.

Each state law under no-fault insurance is unique, and each has its own provisions. The benefit levels and procedures vary considerably, as do the means for settling disputes. Some states allow for arbitration of disputes through the American Arbitration Association, which has an office in most states. In other states, a special arbitration board has been specifically set up to hear disputes under no-fault. While in others, all disputes have to be resolved in a court of law.

Automobile Liability Insurance

Automobile liability insurance differs from no-fault in that under this coverage, a person injured in an automobile accident must prove that a third party, usually one of the drivers or both, was responsible for causing their injuries. Because there is so much controversy over the question of fault, litigation in automobile liability is usually the rule rather than the exception. The amount of payment is always contingent on the amount of liability coverage carried by the responsible driver. In cases of low limits, vocational rehabilitation is not a consideration by the responsible insurance carrier.

INSURANCE INDUSTRY PLAYERS

Claims Adjuster

Most insurance companies hire claim adjusters who act as the investigating arm for the company. Some company adjusters work out of an office while others are traveling employees. Traveling adjuster's responsibilities include direct contact with the injured person, with the employer, and with other parties to determine the cause of the accident or of the disease. While most accidents are usually within the course of employment, diseases are oftentimes a more complex problem. Some diseases are occupational in nature, such as silicosis, while others may be the result of a combination of on and off the job exposures. Therefore, a very complete investigation by the adjuster may be necessary in order to determine compensability.

File Managers

Adjusters, whether traveling or not, usually have little authority on serious cases. They most often have to seek counsel and advice from other emplyees with more authority. These persons with higher authority may be referred to as file superintendents or file examiners. File managers are more experienced people and are oftentimes the person in direct charge of the case. They have the ultimate responsibility and are in a position to make decisions. Contact and cooperation between the rehabilitation specialist and the insurance company claims personnel is a must if joint efforts are to be rewarded by a successful return to work of the injured employee.

Independent Adjusters

Rehabilitation specialists may also come in contact with independent adjusters who are not employees of the insurance company but are employees

of a private adjusting firm. These independent adjusters will act as representatives of the company but usually have limited authority. They are used primarily to make investigations and to contact the injured persons, to establish rapport, and if possible, to settle the case. They are usually retained early in the case to make the investigation, but once it is determined that a rehabilitation nurse or a vocational counselor is necessary, the independent adjuster is removed from the case.

The Physician

The physician plays an important role in all personal injury cases, although the role differs depending on the case involved. In some states under Worker's Compensation, the medical opinion on permanent partial disability governs the amount of disability awarded. In other states, the physician may only express functional limitations, and the amount of permanent partial disability awarded is the sole responsibility of the judge or referee. Usually under Worker's Compensation, the employee has free choice of physician. This practice may have the disadvantage of creating overtreatment, malingering and questionable medical results through shopping for a liberal physician.

Rehabilitation Nurse

The rehabilitation nurse or industrial health nurse is often the first and only contact with the insurance company and the claimant. As a result, they are frequently client advocates. These professionals are often influential in making certain that injured persons are treated by the right physician at the proper time.

Rehabilitation Managers

Some companies have developed structures to meet the needs and requirements of rehabilitation. Some have a physician in charge who acts

as a medical director and directly supervises the activities of the company rehabilitation nurses and other rehabilitation personnel. In some cases, the director may be a person with rehabilitation or vocational background. In all cases, the director usually will set company policy and give guidance and direction on problem cases, but usually will not be involved in the routine file handling. Insurance companies will utilize the services of outside rehabilitation organizations, usually private proprietary, where such service is deemed beneficial to expedite resolution of cases.

SUMMARY

The insurance industry has always been an advocate of early intervention in Worker's Compensation cases involving disability. Today, many companies have "early warning systems" which trigger immediate reports to their home office should a catastrophic injury occur. Also, many companies have "prompt contact programs" on all noncatastrophic injury cases, both under Worker's Compensation and automobile. History has shown that if the injured person is contacted early in the case, the "disability process" is often avoided and a prompt return to work is possible.

This concept provided positive results regardless of what law was applicable or what type of policy was in effect that covered the injury and resulting disability. Most private rehabilitation specialists have accepted these concepts and have geared their approach to comply with these prompt contact programs. They do not wait for the end of the "healing period" to make contact as some state rehabilitation programs may. It behooves the private rehabilitation specialist to zero in on replacement and the preservation of the employee's job when possible. Because this

model, and its flexibility, have shown positive results, it has also been adopted by many nonprofit agencies, self-insurers, and in some state rehabilitation programs such as in New York.

Chapter V

Rehabilitation of the Injured Worker

CHAPTER V

REHABILITATION OF THE INJURED WORKER

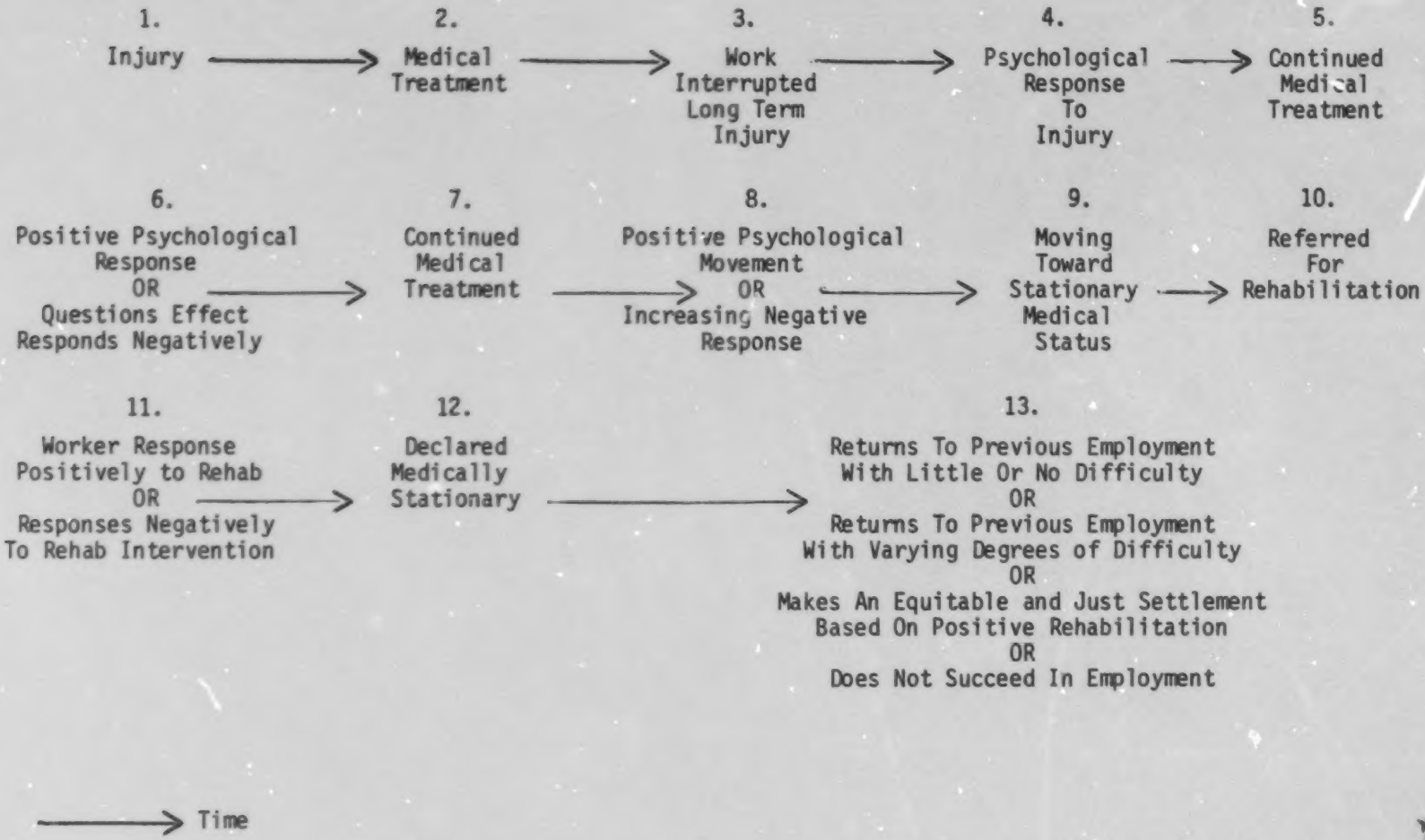
The bulk of propietary rehabilitation work is done for the injured worker. Various types of rehabilitation programs and services have been attempted in working with this population by the industrial insurance carrier in the name of rehabilitation. In some cases, these programs and services have been successful. In many cases, however, these programs and individual services have been less than helpful in assisting the injured worker return to a productive life.

The majority of industrial injured workers complete their rehabilitation process successfully with little or no difficulty. At the same time, however, there are some injured workers who experience great difficulty prior to completing the process successfully or completing the process with limited success. There are also a few injured workers who never complete the process successfully and never return to a productive life even when the medical aspects of the case indicate they can be productive workers. Rehabilitation can make a significant positive difference in the lives of the injured workers in the last two groups.

THE REHABILITATION PROCESS

There are many separate rehabilitation processes. They come together as one as they relate to the whole person. The following flow chart graphically demonstrates the number and relationships of these rehabilitation processes. The processes include: the individual rehabilitation

INDIVIDUAL REHABILITATION PROCESS



process; the medical rehabilitation process; the vocational rehabilitation process; and the legal aspects of rehabilitation.

Individual Rehabilitation Process

The individual rehabilitation process is the individual's ongoing response to all aspects of the injury. The process is described below:

1. The worker sustained an industrial injury.

2. The worker is treated medically for the injury.

3. The injury is severe enough to interrupt work and to be classified as a loss time injury.

4. The injured worker begins immediately to respond psychologically to the injury and to its effect on him or her. Regardless of the severity of the injury, the immediate psychological response is usually more positive in nature then negative. The person usually feels certain that he or she will return to a productive life.

5. Medical treatment for the injury continues. Medical process continues.

6. The injured worker maintains a strong, positive, realistic psychological response to the injury and its overall effects on his or her life. Consequently, the injured worker moves positively towards ultimate rehabilitation success.

(or)

6b. The injured worker begins to question the effect the injury has had to his or her life and begins to wonder what the ultimate outcome will be vocationally, financially, personally, etc. As a result, the injured worker begins to respond more negatively then positively to the injury and to the environment. Usually the person begins some withdrawl from the environment at this time. The person becomes less involved and tends to become more passive and dependent.

7. Medical treatment for injury continues. Medical progress continues.

8. The injured worker maintains a strong positive kind of realistic psychological response to the injury and its overall affects on his or her life. Consequently, the injured worker moves positively toward ultimate rehabilitation success.

(or)

(or)

8b. The injured worker questions, more and more, his or her place in life. "Will I be able to work again?" "What can I do?" "What will become of me?" etc. The continued, increasingly negative psychological response to the injury begins to cause problems for the person in the environment. Personal problems, additional medical problems and demonstrable psychological problems begin to develop.

9. Medical treatment for injury continues. Medical process continues. Physicians indicate that the person is moving toward medically stationary status.

10. The injured worker is referred to formal rehabilitation service. Rehabilitation services requested range from comprehensive to a single service.

11. The injured worker responds positively to rehabilitation intervention, begins to move in a positive direction psychologically, and toward ultimate successful rehabilitation.

(or)

11b. The injured worker responds negatively to the rehabilitation intervention and moves in a negative direction psychologically and physically and ultimately achieves limited rehabilitation, if any.

12. Medical treatment for the injury is concluded. The injured worker is declared medically stationary. Physical restrictions regarding return to work are established. A disability percentage is established.

13. The injured worker successfully returns to his or her previous employment or ultimate employment with varying degrees of difficulty.

(or)

13b. The injured worker successfully returns to his or her previous employment or ultimate employment with varying degrees of difficulty.

(or)

13c. The injured worker makes an equitable and just settlement based on positive rehabilitation approach by the injured worker in the environment.

(or)

13d. The injured worker does not successfully attain any employment.

Medical Rehabilitation Process

The second rehabilitation process is the medical process. Medical rehabilitation is defined by Dorlan (1974) as:

1. The restoration of normal form and function after injury or illness.
2. The restoration of an ill or injured patient to self-sufficiency or gainful employment at his highest obtainable skills in the shortest possible time.

The medical rehabilitation process is closely tied to the injured worker's own rehabilitation process for it is the very basis for many of the person's own positive or negative responses to the injury and to the environment.

During the earliest stages of a person's lost-time injury, the worker is extremely suggestible,i.e., there is a period during which an individual responds positively to rehabilitation efforts. This heightened level of suggestibility, which is referred to as "the window of suggestibility," appears to be tied to the individual's state of personal confusion, feeling of helplessness, and early awareness of the financial dependency on the worker compensation system. The window of suggestibility has a definite time frame of approximately 120 day post-injury. The person is particularly suggestible in the first 30 to 60 days. Everything from the doctor's bedside manner to the setting of a specific time frame for the worker's return to employment impacts disproportionately on the outcome of the injured worker case.

While the medical perspective of the industrially injured worker is vitally important to the ultimate recovery, it is clear that other factors

weigh heavily in the ultimate recovery process of the injured person. Weihofen (1976) states that, "Even if medical and psychological treatment is excellent, so that the patient's life has been saved and protected, unless he or she is helped to find something to do with that life, he or she may succumb to discouragement about ever being able to function normally, earn a living, or live a self-reliant life." The author further concluded that there are many psychological reactions to injury including depression, resentment, dependency, anxiety about finances and his or her chances for further employment, unrealistic thinking and planning, and negative self-concept. These psychological sequels of the injury may be more destructive to the person's ability to function than anatomic physiologic loss.

In further connecting physical and psychological factors, Phyllips (1964), concluded that for many years physicians and psychiatrists have been interested in the relationship between physical disability, accidents and illness, and these psychological interactions. Profiling the industrially injured worker necessitates taking this relationship into prime consideration.

The Vocational Rehabilitation Process

The vocational rehabilitation process begins for the injured worker at the time of referral for rehabilitation services and is defined as:

> The process of providing in a coordinated manner those comprehensive services deemed appropriate to the needs of a disabled or handicapped individual, in a program designed to achieve objectives of improved health and welfare with the realization of his or her maximum physical, social, psychological and vocational potential for useful and productive activity. The components of rehabilitation services are melded into the rehabilitation process when the disabled individual must have assistance and it is (1) beyond his personal, social and economic adjustment, and (2) beyond the services available in his usual daily experiences.

> Such assistance continues through a time-limited period during which significant and observable improvement takes place. (CARF, 1976)

Like the medical rehabilitation process, the vocational rehabilitation process is closely linked to the injured worker's own rehabilitation process for it, too, is the basis for many of the person's positive and/or negative responses to the environment.

Legal Aspects of the Rehabilitation Process

Surrounding the three rehabilitation processes described above, is still another process which invariably has a tremendous effect upon the injured worker. It is inexplicably tied to the responses the injured worker has to the injury and ultimate successful rehabilitation. The legal rehabilitation process may be defined as:

> The process of providing in a coordinate manner, those comprehensive legal services deemed appropriate to the needs of the injured worker. The goal is to allow the injured worker to become self-sufficient or to be gainfully employed at his or her highest attainable skills in the shortest period of time. Also, it seeks to protect the injured worker's income and interests in the event the worker returns to alternate employment or cannot return to gainful employment.

Weihofen (1976) states that, "A truly competent lawyer will be as solicitous of his client's psychological rehabilitation as his physical, and will make sure that any rehabilitation program entered into will include counseling by a psychologist or a social worker or both, to assess the client's motivation and to help him adjust to his physical loss and its effect on his personal life. The most valued recovery is the self-respect that comes with independent earning power. The nonmedical rehabilitation workers can also help with such economic problems as arranging for alternative income and with stabilizing family relationships."

The window of suggestibility, that played a major role in the medical rehabilitation of the injured worker, is just as important in the legal process of rehabilitation of that worker. When introduced into the industrially injured worker's effort towards recovery, the attorney can become either of great assistance in the recovery process or a major barrier to formal rehabilitation.

PSYCHOLOGICAL IMPACT OF INJURY

Behan-Hirchfiel (1966) stated that, "Those patients with industrial injuries are highly suggestable at the moment of injury. Thus, their personal response to the doctor is of utmost importance." This suggestibility also extends to the impact of co-workers, family members, employer, claim adjuster and other members of several other professions with whom they may come in contact.

This "window of suggestibility" suggests several extremely important factors which should be emphasized. The first is that the injury affects the whole person. The second, is that the rehabilitation process for the injured worker begins immediately at the time of injury from both the psychological and medical aspect. As the initial response to injury is driven by a desire to recover, it can be capitalized upon to assist the injured worker in ultimately returning to a productive, meaningful life. If the psychological response continues to be a positive one, the injured worker continues to progress through the rehabilitation process toward a successful completion. In general, the longer the injured worker is forced to cope with a "nonwork" situation, the more difficult it becomes for the person to maintain a strong, positive and realistic psychological response toward that situation.

In an unpublished article resulting from a two-year study with the Arizona Worker's Compensation Fund, Ross (1966) stated that, "From the moment of injury, a sequential time bomb is set. As the minutes, days, weeks and months pass by, this time bomb affects how the injured worker is responding to the accident process and how ultimately it will explode in final nonreturn-to-work behavior and ultimate litigation."

Malingering

Another concept that is directly related to the psychological response an industrial injury has on the worker is that of malingering. Those defending an employer's position identify certain characteristics of the industrial injured worker as malingering.

There has been a great deal written about malingering, particularly with respect with definitions of malingering, as well as the reasons for it. Secondary gain, both financial and emotional, is a term that is in common usage in dealing with injured workers who are resistant to returning to productive employment. A great amount of time, energy and money is spent in working with all the problems surrounding the negative aspects of malingering. Consideration must be given to all aspects of a given situation including medical, psychological, sociological, economic and legal. We cannot choose an isolated instance of behavior on the part of the industrially injured and generalize as to their overall motivation or goal. The following factors may shed some light on the concept of malingering:

1. Some injured workers are predisposed to respond to their industrial injury in what appears to be a malingering manner.

2. Specific behavioral malingering does exist in the Worker's Compensation system. Research suggests that conscious or primary malingering exists in approximately two percent of all lost-time injuries.

3. Malingering is primary only when it is a conscious effort to deceive or defraud and secondary when the individual is without understanding or premeditation in his or her behavior actions.

4. Primary malingering is seldom affected by any type of rehabilitation intervention. However, the exposure of this type of malingering to intense rehabilitation actions will often expose it early in the recovery process. If primary malingering is to be averted, early referral for the spectrum of rehabilitation services is the most effective and successful method of treating it.

5. Secondary malingering can be diminished by rehabilitation intervention. The profile of the industrially injured worker, its timeline, its window of suggestibility and the fact that good faith exists between the insurance carrier or employer tend to eliminate the need for malingering action. Early rehabilitation intervention yields the most significant positive results with this tendency.

6. Long periods of time in the Worker's Compensation systems appears to create malingering behavior in the worker.

7. Introduction of a plaintiff attorney appears to increase malingering behavioral manner in the worker.

Total Rehabilitation

The most common error in defining rehabilitation is limiting the definition to a single service. For example, expert witnessing can be a subservice within the rehabilitation service model but cannot stand alone as a rehabilitation service. The information testified to by the expert must come from other components of the rehabilitation model, i.e., vocational testing, labor market surveys, occupational and physical therapy and medical reports. When rehabilitation is viewed as a single service in a vacuum, e.g., placement, by referral sources, it almost always fails. The application of one or two services, must not be viewed as rehabilitation but only as a part of a rehabilitation process. One of the most misused concepts underlying referral of an injured worker for

rehabilitation services is to define the single service of job placement as rehabilitation. Job placement is not synonymous with rehabilitation but rather is the end product of a successful coordination of the total rehabilitation process. Also, rehabilitation is not synonymous with retraining in the sense that every injured worker should be retrained for an occupation different from the one he was pursuing at the time of injury. Each injured worker profile is a unique one, and rehabilitation must be considered as a unique process the person is going to pursue so as to return to productive employment.

SUMMARY AND CONCLUSIONS

Most often industrially injured workers, particularly the worker who is entering the accident process the first time, is confronted with an array of situations that they do not begin to understand. The established system for the industrially injured is laden with anxiety and stress that is magnified by the claimant's inability to cope with their innermost feelings of insecurity and inadequacy. Any disability serious enough to leave a person permanently incapable to returning immediately to work almost always leaves a host of psychological, sociological, financial and family problems in its wake. Long periods of pain and medical treatment bring on moderate to severe emotional depression. Unemployment causes feeling of loss of status. Isolation from the social stimulus of work is felt acutely.

Long periods of unemployment frequently lead to dependency on food stamps, Medicaid, charitable dental clinics for the children, free counseling services at the mental health center and other free services. Use of these benefits or services tend to become disincentive to a return to

work as the case progresses. It is not uncommon to see an individual's full daytime hours filled with appointments at the physician's office, for physical therapy treatments, counseling sessions, visits to the food stamp office, visits to his or her insurance claim office, visits to the unemployment office, to the Social Security office, and finally, to the vocational rehabilitation office. They are often times so busy that it is difficult for them to work in an appointment with the latter and most important segment of this process - the vocational rehabilitation specialist. Being so preoccupied with these activities, such people literally do not have the time or the energy to work. Eventually, work becomes the alien concept.

Chapter VI

Issues, Implications and Considerations

CHAPTER VI

ISSUES, IMPLICATIONS AND CONSIDERATIONS

The past years research on private proprietary rehabilitation raised a number of unresolved issues. The following chapter focuses on the most critical of these issues, discusses implications and outlines consi-erations for state agency action.

ISSUE I
WHAT ARE IMPLICATIONS OF MORE INTENSIVELY SERVING THE WORKER'S COMPENSATION CLIENT?

Size of Market

Total dollars billed by private sector rehabilitation to third party payers in 1970 was probably less than $250,000. In the year ending December 31, 1982, billings were approximately $450,000,000. The bulk of this business is Worker's Compensation cases. Growth rates have been estimated to be over 30% per year. The growth of private proprietary rehabilitation has been driven primarily by expansion of Worker's Compensation benefits, including provisions of specific rehabilitation benefits. The size of this market is seen in the fact that for the year ending December 31, 1980, U. S. employers paid $15,166,472,000 in Worker's Compensation premiums. Employers in California paid the largest amount for any state at $2,686,073,000. For the same time period nationally, $10,194,161,000 was paid to injured workers by insurance carriers for the costs of work related claims.

During the fifty year period ending in 1970, the predominance of vocational rehabilitation counseling and service coordination was supported

through public funding. Since the 1970's, public sector rehabilitation counseling and service coordination was supported through public funding. Since the 1970's, public sector rehabilitation growth has stabilized and both private nonprofit and private proprietary programs have developed and expanded to meet market needs. Nevertheless, the current impact of public sector rehabilitation programing is evidenced by the fact that in Federal Fiscal Year 1983, 943 million federal dollars were earmarked to support this effort.

The recent federal emphasis has been on the severely handicapped and independent living. At the same time, state Worker's Compensations laws were modified to include vocational rehabilitation as a benefit in permanent partial disability cases.

The above facts are reflected in the finding that Worker's Compensation cases only represent three to ten percent of state vocational rehabilitation caseloads (RSA, 1980). In no federal region does the number of clients receiving Worker's Compensation benefits as primary source of support reach nine percent of the total caseload.

A number of state agencies are actively considering increasing their services to Worker's Compensation programs. These state agencies can move immediately and apply the Ninth Institute's marketing concepts to their interactions with insurance companies and self-insured employers. Others may follow the lead of those state agencies that have taken steps to move to a fee-for-service model <u>without</u> abandoning the State/Federal partnership. States which have taken this step include California, Georgia, Minnesota, Michigan, Oregon, Colorado, Nevada and New York. The article by Smith and Sawisch (1983) documents the difficulties state agencies experience when

taking steps to compete in this marketplace. Uncataloged are many other state agencies who have moved to capture as much participation from third-party payers as their jurisdictions and the voluntary pursuers of rehabilitation (Worker's Compensation and no-fault primarily) will permit.

Some states are charging an hourly fee for services. They are able to recover staffing and other direct and indirect costs from insurance providers.

State agencies considering adopting the fee-for-service model should consider the following steps:

1. Make contact with the state agencies in this practice.
2. Review Chapter II, "Proprietary Rehabilitation Defined," Chapter IV, "Rehabilitation of the Injured Worker," and Chapter V, "The Marketplace" to select those best practices and models that would merit adoption by your agency as well as assist you in defining the market segment you wish to attack.
3. Reread Chapter I, "Perceptions, Truths, and Partial Truths" and decide which of the half truths about your organization are used by your competition to gain entry into markets. These beliefs about your organization's shortcomings are used to your competition's advantage.
4. Decide how much truth there is to the perceptions. (A survey of potential customers will provide invaluable input.)
5. Design the kind of program that will perform to change the perceptions and gain a competitive edge.

Implication

- Agency administrators should consider reestablishing their role in serving the Worker's Compensation client.
- Agency administrators should consider the merits of using Worker's Compensation insurance benefits as a similar benefit or charging a fee for service using an hourly rate.
- If a fee for service is chosen, then agency administration should consider specialists with Worker's Compensation caseloads supported by the funds generated.

ISSUE II
WHAT PRACTICES CAN VOCATIONAL REHABILITATION AGENCIES ADAPT OR ADOPT FROM PROPRIETARY REHABILITATION

There are many business practices of proprietary companies which may be instructive to state vocational rehabilitation agencies. One significant feature of proprietary rehabilitation companies is their emphasis on the marketing of their services. If vocational rehabilitation agencies are to remain competitive and to maintain their funding base, they need to become significantly better at marketing their programs and services. The Ninth Institute on Rehabilitation Issues' publication, Marketing: An Approach to Placement begins to describe those factors which must be part of a good marketing plan including market analysis and product development. Person to person sales and advertising are additional aspects which must be included. Failure to pay attention to the prime importance of marketing may result in dire consequences for state agencies.

A number of features or emphasis in the proprietary rehabilitation companies methods of providing services may also be instructive. For example, proprietary rehabilitation practitioners place great emphasis on their initial interview with their client. It generally includes a thorough review of all medical, financial, social and educational and vocational history. What distinquishes their interviews is the thoroughness of the information gathering, the close attention to the individual's functional strengths and weaknesses and specifically a detailed review of the individual's vocational history and performance as it applies to job placement. Many vocational rehabilitation agencies are now looking carefully at functional assessment concepts not only to assist in

vocational planning but also to aid in the initial screening and eligibility decision making process.

In regards to case planning, proprietary rehabilitation uses a priority system which places primary emphasis on job placement. Vocational rehabilitation agencies generally do not have a similar clearly articulated priority system. (Note: Mandated order of selection should not be confused with a client service priority system.) Many state agencies have, however, begun shifting attention to counseling and placement plans only. Such plans are appropriate after determining that an individual can either return to former employment or can return to another similar job using transferable skills.

A prior chapter discussed, at some length, the "window of suggestibility" and the critical need to return former workers to employment as quickly as possible. Employers and Worker's Compensation insurance carriers know the need for quick action and expect it for their employees/claimants. If vocational rehabilitation agencies are to serve this population well, they must have the same sense of urgency.

Proprietary rehabilitation companies are able to serve the Worker's Compensation client efficiently because they have specialized staff, provide timely services, and allow staff to work intensively with clients by assigning small caseloads. According to Sink's (1983) findings, 65% of the private counselors carry 25 or less clients at one time.

State agencies should consider whether these approaches could work well for them. If they do not work for all of the agency's clientele, they may never-the-less work well with their Worker's Compensation cases. It is not feasible to redirect an entire agency around concepts and practices which apply to only a part of the total caseload. Consequently,

specialization and the development of specialized caseloads or units may be an answer. The alternative is to direct staff to develop specialized approaches and orientations to the various populations within their caseloads.

Proprietary rehabiliation companies are generally entrepreneurships; while public agencies are not. However, in the context of current political and fiscal realities, vocational rehabilitation agencies are being forced to include entrepreneurail concepts as much as is possible. It is recognized that including these concepts requires imagination and determination.

Major aspects of the entrepreneurial model are marketing and incentive schemes. Very often there are no, or only negative incentives for agencies to perform and be cost effective. Although incentives at the agency level may be limited, there do exist incentive schemes for employees. Weighted case closure and outcome based pay systems begin to address this issue but more needs to be done. Such schemes can also assist agencies to successfully compete with proprietary rehabilitaiton for qualified and trained staff.

If an agency decides to employ specialized staff and caseloads, a major consideration is that of pay differentials and incentive schemes. Poorly conceptualized systems breed jealousy and undue intra-agency competition.

Although there are many differences between vocational rehabilitation agencies and proprietary rehabilitation companies, there can be no question that they can learn from one another. When exemplary practices cannot be adopted, they still may provide concepts and ideas which can be adapted to enhance the way vocational rehabilitation agencies do their work.

Implications

- Agencies might want to consider developing a clearly articulated "priority system" paralleling the one existing in worker's compensation rehabilitation.
- Quick action is clearly a critical factor in the rehabilitation of injured workers. State agencies should examine the average length of time from injury to referral, from referral to diagnostic statuses and from diagnostic status to plan implementation and develop sytems to expedite the movement of cases.
- Agencies should consider permitting staff to carry small caseloads to allow intensive work with clients.
- Agencies should consider innovative incentive schemes for their employees to improve productivity and so as to better compete with proprietary rehabiliation companies.
- Adopt/adapt specific case practices to expedite case movement.

ISSUE III
SHOULD RSA FUNDS BE USED TO TRAIN COUNSELORS FOR PRIVATE PRACTICE (PROPRIETARY REHABILITATION)?

The need for graduate training programs for rehabilitation counselors is universally understood. However, disparities exist concerning the makeup of the core curriculum of the training program. Professional organizations have published a series of standards relating to the content of rehabilitation counselor education and the job of the rehabilitation counselor. The development of rehabilitation counselor education training programs has been based upon these standards, but their terminology is too broad and generalized to indicate what specific skills and knowledge are needed to train competent rehabilitation counselors.

There has been significant changes in the markets for trained professionals in rehabilitation. A recent study by Menz (1983) indicates

great demand for rehabilitation facility personnel (vocational evaluators, work adjustment counselors, placement and case managers). Matkin (1982) noted that the State/Federal program no longer can absorb vocational rehabilitation counselor graduates as it did in the 60's and 70's. This report, prepared by NARPPS Training and Research Committee expressed dissatisfaction with traditional counselor training and suggested the following additions to modify existing rehabilitation counselor training curriculums:

- Insurance issues in the rehabilitation process includes Worker's Compensation history
- Medical case management
- Vocational expert testimony

They recommended that these existing courses receive increased emphasis:

- Legal and ethical issues (includes confidentiality of information)
- Vocational evaluation methods
- Occupational information
- Medical and psychological aspect of disability
- Job analysis and restructuring
- Job development and placement
- Case management
- Gathering, synthesizing, and reporting
- Administrative management coursework
- Field experiences in private, proprietary agencies

However, some people believe the rapid growth in private practice rehabilitation may be tapering off and may soon plateau. Consequently, training institutes should do market research to ascertain future market trends before changing curriculum.

The State/Federal program will continue to have staff development and training needs. Their counselors continue to need training in interviewing and vocational counseling, functional assessment, caseload management, plan development, community resources, psychology of disability, job placement, along with other subjects.

In spite of increased demand for training, the dollars earmarked for training have remained the same or in some years decreased. In addition, the number of young people willing to enter the helping professions nationally has decreased. Consequently, many universities are having difficulty adding new programs which require additional staff members.

The different needs for trained staff by both vocational rehabilitation agencies and proprietary rehabilitation creates a strain on limited resources. It is expected, however, that universities will continue their concern for training professionals who can provide quality services to disabled people wherever they are employed. Specific job related training may require increased inservice or short-term emphasis rather than changes in general training at universities.

Implications

- Increased emphasis on new courses in Worker's Compensation, medical management and forensic rehabilitation will necessitate a reduction in the social services orientation current students obtain.
- There will be a decrease in the emphasis on advocacy for the handicapped in general.
- University training programs will need to retrain or hire teachers with different background to develop and teach the new curriculum if adopted.
- Eventually, the State/Federal program will have to begin hiring new counselors due to attrition.

- There is currently a need for significant numbers of trained personnel in proprietary rehabilitation. They also are of significant aid to disabled people.

ISSUE IV
ARE COMMON PROFESSIONAL STANDARDS NEEDED?

Agency direction is influenced primarily by emphasis on certain populations as directed by Rehabilitation Services Administration priorities and regulations. However, attention has again been brought to the large Worker's Compensation universe now being addressed primarily by the private proprietary provider. With this renewed concern and potential overlap and interaction between the state agencies and proprietary provider comes a need to consider the impact of behavior and practices of one sector on the other.

Consequently, the merits of developing standards in the areas of practices and behavior is receiving increased attention. Currently there are no clearly defined consistently applied standards for state agency personnel. All that is available for a perspective on expected behavior and practice can be found in the NRA standards, certification standards and confidentiality standards (see appendix for examples of codes of ethics and professional standards).

As we have seen, a number of providers, other than the traditional vocational rehabilitation counselor, are now providing services for the injured workers. As a result, there is a growing argument for establishing program and service standards. These standards should be based on principles for private proprietary and state agency professionals alike.

The rationale for the development of standards has several dimensions that seem to be accepted by most of the practitioners in the private sector,

and to some degree in the public sector. One dimension that has across the board support is professionalism. Vocational rehabilitation counselors would contend that the services they provide and the training they have taken should have the same status as social workers, psychologists and others. This would require a licensure and certification process to be setup in the various jurisdictions. The establishment of standards relative to training, experience and competency would do much to achieve this end.

Another critically important dimension from the private sector viewpoint, would be credibility in the eyes of third party payers and the courts. Standards that are widely accepted and consistently maintained at a high level, enhance the credibility and worth of the information and the recommendations being presented by the practitioner. This is particularly important when testimony is being given in a case before the courts. Practitioners must establish that they are an expert in the area of testimony being given; that they have professional credentials and considered expert in their fields. Standards could also provide a basis for choice among providers for lay people.

Another area of importance in the private sector is the generation of fees based on high standards, credibility and performances. The bottom line in the private sector is to make money. Whatever can be done to make the service one of better quality and therefore, more in demand, will usually result in a higher return to the provider of the service. At the same time it will result in higher credibility among rehabilitation professionals.

Public sector programs and service standards are controlled by laws, regulations and the civil service structure within each jurisdiction. The

Rehabilitation Act of 1973, as amended in 1978, describes the program, what services will be provided and the expected outcomes. Most states have adopted minimum standards of training and experience regarding who can be considered a vocational rehabilitation counselor. Some attention was given to the desirability of improved professional standards among state agency personnel in the pending reauthorization of the Rehabilitation Act. As proposed, it calls for insertion of the word "professional" as appropriate in parts in the Act. This could well provide the impetus for the delineation of standards to at least meet the intent of the Act.

The private sector is not (as yet) controlled by laws and regulations. There are many people with very different backgrounds providing rehabilitation services within the industry. They are striving to encompass a broad range of discipline under an umbrella of certification that would have universal acceptances. Much of what is included is modeled after the public sector standards and many companies require Certified Rehabilitation Counselor certification or its equivalent. There are numerous private organizations and associations that have established standards for their discipline, such as, nursing, vocational evaluation and assessment, psychological testing and others. Some states also have licensure and certification for the named disciplines. Most of the private companies require their employees to meet the minimum requirement of their speciality, as well as, experience in the field of vocational rehabilitation.

It is quite apparent that the field of vocational rehabilitation is in a period of changes. The changing market place has forced all in the field to look at what has happened, what is happening and what is likely to happen in the future. No longer is the provision of vocational

rehabilitation services to the disabled the sole domain of the public sector programs. We are, however, all members of the same profession and could consider jointly and separately how we can best serve the needs of our respective clients while maintaining professional competencies and manage to insure our credibility as a profession.

Implications

- With overlap between the private and public sector, common standards can provide the basis for professional behavior, image, credibility, more valid pay practices and censure for the rehabilitation profession.
- Of vital importance is the implication for improved quality of service where at least minimal valid requirements are met by professionals in their respective speciality areas.
- Valid professional standards for all rehabilitation professionals will provide a basis for consistant and appropriate advocacy for the disabled.

ISSUE V
WHAT SHOULD THE RELATIONSHIP BE BETWEEN VOCATIONAL REHABILITATION AGENCIES AND PROPIETARY AGENCIES?

AREAS OF COOPERATION

Griswold-Scott, (1979), one a state director, the other supervisor of the state agency's Worker's Compensation, recommended mutual collaboration in several areas, including:

- Setting and maintaining mutual standards
- Mutual training
- Supportive political action and public education

Since 1979, the Michigan agency and proprietary rehabilitation firms have had a Memorandum of Understanding designed to minimize and resolve

conflicts that would lead to delays or hardship on the injured worker. Griswold (1981) surveyed 20 private, proprietary agencies to gain their views on their relationship with the state agency; 9 of the 12 that responded claimed to have a working agreement with the state agency; five routinely made referrals to the state agency, and two claimed mutual planning.

In addition, referrals were made by the Michigan Rehabilitation Service to private, proprietary firms for psychological testing, vocational assessment and counseling. When asked to characterize the relationship with the state agency, all private firms wanted improved relationships with the state agency but few had specific recommendations and were split on the question of free exchange of information. Agencies and proprietary firms want a process that may lead to honest communication and greater appreciation of our mutual objectives. Additional areas in which there might be mutual collaboration, including job placement, support for private nonprofit facilities, counselor education programs, and political action to enhance appropriate funding for rehabilitation services.

Implications

- Discuss feasibility and best methods for technical exchange on program development, best practices in service delivery and management that could include training programs.
- Explore joint political action to create rehabilitation benefits in worker's compensation and no-fault in state insurance legislation.
- Investigate the need for a formal cooperative arrangement between agencies including purchase of services.

Reference/Bibliography

REFERENCES/BIBLIOGRAPHY

Adjuster Speeds Rehabilitation, Settlement: Insurer. Business Insurance, June 25, 1979, Vol. v13n13, p. 45.

Akabas, Shelia, Gottlieb, F. Amelia, and Yasser, Roslyn. Preventive Rehabilitation: Untapped Horizon for VR Agencies, RSA Grant 15-P57807/2-04.

Alt, Susan. Spinal Injuries Need Agressive Help, Expert Warns. Business Insurance, October 16, 1978, Vol. v12n21, p.49.

Analysis of Worker's Compensation Laws, Washington, D.C.. U.S. Chamber of Commerce, 1982.

Behan, Robert C., M.D. and Hirschfield, A.H., M.D. Archives of Environmental Health, May, 1966, Vol. 12.

Berkowitz, et.al. Measuring the Effects of Disability. New Brunswick, New Jersey: Rutgers University Press, 1979.

Bond, Thomas R. Worker Compensation Court Fights Can Hurt. Business Insurance, June 2, 1980, Vol. v14n22, p. 18-20.

Boone, Linda, Corthell, Dave, and et.al. Marketing: An Approach to Placement. Menomonie, Wisconsin: Research and Training Center, University of Wisconsin-Stout, 1982.

Botterbush, Carl. A Comparison of Computerized Job Matching Systems. Menomonie, Wisconsin: Materials Development Center, University of Wisconsin-Stout, 1983.

Bowe, Frank. Rehabilitation America. Harper and Row, 1980.

Brandon, Thomas L., M.S., and Rastatler, Charles J., E.D. Valpar Composite Rehabilitation Management.

Carlquist, Carl. Comparison of Rehabilitation Provisions Under Workers' Compensation. Minnesota Workers' Compensation Report, February, 1983, No. 4.

Diamond, Joseph. Big Savings Seen in Insurer Rehabilitation Services. National Underwriter (Property/Casualty), November 19, 1982, Vol. 486n47, p. 3, 15.

Disability in the United States: Extent and Economic Impact. Health Insurance Association of America, Washington, D.C., 1980.

Ehrenreich, Morris. New Insurance Tool in Claims Cases. National Underwriter (Property/Casualty), July 9, 1982, Vol. v86n28, p. 21, 24.

Ehrenreich, Morris. Total Rehabilitation is a Job that Pays. Journal of Insurance, Jul., August, 1979, Vol. v40n4, p. 13-16.

Evert, David R. Dealing with Disability. Business Insurance, August 4, 1980, Vol. v14n31, p. 17.

Flynn, Michael P., Leone, Charles A., and Meeker, Stephen S. Worker's Compensation Third Party Suits in the Construction Industry. CPCU Journal, March, 1981, Vol. v34n1, p. 48-53.

Ford, Robert E. Worker's Compensation: Will it be the Second Hospital Insurance Crisis. Hospital Financial Management, April, 1981, Vol. v35n4, p. 22-24.

Geisel, Jerry. Florida Plan Ponders Worker's Compensation Benefits Based on Lost Wages. Business Insurance, May 1, 1978, Vol. v12n9, p. 3.

Gianforte, Grace. A discussion of the differentail factors affecting the re-employment of the industrially injured. Paper handed out at Rehabilitation Institute of Chicago Conference, Chicago, Illinois, March 26, 1982. (Paper dated 1980).

Gianforte, Grace. Rehabilitation Through Job Placement. National Underwriter (Property/Casualty), December 5, 1980, Vol. v84n49, Part I, p. 22, 32.

Goepel, Pati and Adams, John. Work in Managing and Employing the Handicapped, 1981, Chapter 5.

Griswold, Peter. The Relationship of Private Sector Rehabilitation to Traditional Rehabilitation Systems, in a book by Tom Backer (Ed).

Griswold, Peter and Scott, James W. The State Rehabilitation Agency and Private Rehabilitation - A Partnership Long Overdue. Journal of Rehabilitation, July, 1979, 45 (3), 22+.

Gutowski, Michael. Rehabilitation in the Private Sector: Changing the the Structure of the Rehabilitation Industry. Washington, D.C.: The Urban Institute, September, 1979.

Harrison, Allan J. What's Wrong with Worker's Compensation? The Lump-Sum Payment. Illinois Business Review, December, 1979, Vol. v36n10, p. 1-4.

Harrison, Allan J. Worker's Compensation: Should the Law Be Renamed "Insurers' and Attorneys' Compensation Act." Illinois Business Review, February, 1982, Vol. v39n1, p. 5-8, 11-12.

Herrick, William, et.al. Computer Assisted Rehabilitation Service Delivery. Eighth Institute on Rehabilitation Issues, May, 1981.

Investigation of the Career Information Needs of the Handicapped, Final Report, Michigan Occupational Information Coordinating Committee (MOICC).

Kasper, Daniel. An Alternative to Workmen's Compensation. Industrial & Labor Relations Review, July, 1975, Vol. v28n4, p. 535-548.

Koch, D.L. Shared Destiny, Vital Speeches, October 1, 1982, 48, p. 738-742.

Kosmo, Richard C., Degner, Helen, and Maronek, William H. Improving Relationships between State Agencies and the Insurance Industry. Journal of Rehabilitation Administration, Fall, 1983.

LaFon, R. Private Communication, 1983.

Lawrence, Deneen J. and Hessellund, Thorvald A. Vocational Rehabilitation of the Injured Worker, 1981.

Maes, John. Rehabilitation, Annuities Trim Cost of Injuries: Expert. Business Insurance, June 25, 1979, Vol. v13n13, p. 44.

Maisonpierre, Andre. Rehabilitation: Problems & Possibilities. National Underwriter (Property/Casualty), November 21, 1980, Vol. v84n47, p. 16-17.

Matkin, R., et.al. Rehabilitation Education Curricula: Preparing Counselors to Enter the Private, For-Profit Sector. Training and Research Committee of the National Association of Rehabilitation Professionals in the Private Sector, June, 1982.

McKee, Mary Ellen. Minnesota Plants Seeds of Workers Compensation Savings. Business Insurance, June 11, 1979, Vol. v13n12, p. 4.

McMahone, B.T., and Matkin, R.B. Preservice Graduate Training Needs of Rehabilitation Counselors: Results of NARPPS and NCRE Task Force Recommendations. Rehabilitation Counseling Bulletin, 1983, 27, 1.

McMahone, B., Matkin, R., Growick, B., Mahaffey, D., and Gianforte, G. Recent Trends in Private Sector Rehabilitation. Rehabilitation Counseling Bulletin, 1983, 27, 1.

Menz, F.E. Manpower Needs in Rehabilitation Facilities: 1980-1990. Menomonie, Wisconsin: Research and Training Center, University of Wisconsin-Stout, 1983.

Miller, John H. Disability Insurance, An Assessment of Its Social Value. CLU Journal, July, 1978, Vol. v32n3, p. 12-24.

Millus, Albert J. A Monopolistic Workmen's Compensation System - An Anachronism. Best's Review - P/C, March, 1977, Vol. v77n11, p. 16, 19, 72-76.

Mounts, Gregory J. Labor and the Supreme Court: Significant Decisions of 1979-80. Monthly Labor Review, April, 1981, Vol. v104n4, p. 13-22.

Neill, Debra Hurst. Employer Subrogation: The Effect of Injured Employee Negligence in Workers' Compensation/Third Party Actions. San Diego Law Review, March, 1981, Vol. v18n2, p. 301-323.

New Service Treats Injuries to the Mind in Workers' Compensation Cases. Business Insurance, June 11, 1979, Vol. v13n12, p. 34.

Norris, Eileen. Rehabilitation Called Key to Workers' Compensation. Business Insurance, July 27, 1981, Vol. v15n30, p. 24.

Norris, Eileen. Catastrophic Workers' Compensation Injuries Could Hurt Reserves: Reinsurer. Business Insurance, May 3, 1982, Vol. v16n18, p. 51.

Norris, Eileen. Wage-Loss System Won't Work in Some States, Attorney Says. Business Insurance, October 25, 1982, Vol. v16n43, p. 73.

Nunn, Arya Safa. Rehabilitation: A Word Meaning Hope. Journal of Insurance, January/February, 1982, Vol. v43, p. 17-24.

Ong, John. Vital Speeches, July 15, 1982, 3, 19.

Palisano, Peg. Ohio's Rehabilitation Program Moves Smoothly into Second Gear. Occupational Hazards, December, 1981, Vol. v43n12, p 67-71.

Peisher, Joan. 1979 Study of 240 Closed Cases; Nationwide Insurance Study. Rehabilitation Reports, 1981.

Phillips, E.L. Some Psychological Problems Associated with Orthopedic Complaints. Current Practice of Orthopedic Surgery, February, 1964.

Pope, A. Poetical Works. Essay on Criticism, Line 335.

Private Services and Vendor Guidelines. Hartford, Connecticut: Aetna Casualty and Surety Rehabilitation, 1980.

Program Models for Projects with Industry, Research Utilization Laboratory, RUL #9, RSA Grant #22-P-57776.6.

RSA, National Caseload Data from R-300, 1981.

Ross, Donald R., Ed.D. A Study of Arizona Industrially Injured Workers, State Compensation Fund, 1966.

Ross, Donald R., Ed.D. Private Practice in Rehabilitation, 1979. Unpublished article.

Ross, Eleanor. Legislative Trends in Workers' Compensation. Journal of Rehabilitation, July/August/September, 1979, Vol. 45, No. 3, p. 20-23.

Rule, Warren and Keith Wright. Rehabilitation's Unherolded Partner: Economics. Journal of Applied Rehabilitation Counseling, Winter, 1981, 12, 4.

Rundle, Rhonda L. Workers' Compensation: California Firms Pay Price of Rehabilitation Law. Business Insurance, January 28, 1980, Vol. v14n4, p. 11-12.

Rundle, Rhonda L. Rehabilitation: Debate Centers on Right Route. Business Insurance, July 6, 1981, Vol. v15n27, p. 1, 25.

Rundle, Rhonda L. Limit Use of Attorney in Compensation Case: Lawyer. Business Insurance, March 29, 1982, Vol. v16n13, p. 3, 23.

Scott, Norma. Mandatory Plan Can Help Claimants, Insurers. National Underwriter (Property/Casualty), November 19, 1982, Vol. v86n47, p. 20-21.

Smith, Harry, and Sawisch, Leonard. Injured Worker Rehabilitation in Michigan. Rehabilitation Counseling, September, 1983, 271.

Smith, Phil, Armstrong, Thomas, and Lizza, Gretchen. I.E.'s (Industrial Engineers) Can Play a Crucial Role in Enabling Handicapped Employees to Work Safely, Productively. Industrial Engineering Magazine, Special Series on Ergonomics, 1982.

Stoddart, Carl J. Rehabilitation and Reinsurance. National Underwriter (Property/Casualty), May 21, 1982, Vol. v86n21, p. 29, 40-41.

"Strains and Sprains," A Worker's Guide to Job Design, UAW, Pub. #460 ($1.00 each, 8000 East Jefferson, Detroit, Michigan 48214).

Stundtman, Stundtman, Raseur, Lewin, and Sink. The Role of Private Rehabilitation: Founder Catalyst, Competitor. Journal of Rehabilitation, July, 1979, 45, No. 3., 16-20.

Tebb, Alan. Getting the Injured Worker Back in the Labor Market. Risk Management, June, 1982, Vol. v29n6, p. 12-20.

Trimble, Michael R. Post-Traumatic Neurosis, Chichester, John Wiler & Sons, 1981.

Waters, Gilbert. Florida's Workers' Compensation Rehabilitation Program Gets Results. Risk Management, July, 1981, Vol. v28n7, p. 21-24.

Waters, Gilbert. Rehabilitation Services Can Cut Workers' Compensation Costs. National Underwriter (Property/Casualty), April 30, 1982, Vol. v86n18, p. 21, 34.

Weihofen, Henry. Rehabilitation for the Injured Client. The Journal of Legal Professions, Spring, 1976, Vol. 1, University of New Mexico School of Law.

Workermens' Compensation Study Sees Altered Employee Role. Commerce America, February 28, 1977, Vol. v 2n5, p. P4-5.

Appendix

APPENDIX

STANDARDS FOR TRAINING AND EXPERIENCE
STANDARDS AND ETHICS (NARPPS)

Professional Conduct by Discipline

The member is obligated to maintain technical competency at such a level that the recipient receives the highest quality of services that the member's discipline is capable of offering. The implementation of a rehabilitation plan for a client is a multidisciplinary relationship in such a way to facilitate the contribution of all specialists involved for maximum benefit of the recipient of services and to bring credit to each discipline.

Minimal Standards for Service Delivery

Standards shall apply to the persons who are providing the services. The services and submission of reports shall be provided in a timely fashion and shall respond to the purpose of the referral and include recommendations, if appropriate. All reports shall reflect an objective, independent opinion based on factual determinations within the provider's area of expertise and discipline. The reports of services and findings shall be distributed to appropriate parties and in compliance with all applicable legal regulations.

The member shall render only those services that the member is competent and qualified to perform. The member has an obligation to withdraw from a professional relationship if it is believed that the participation will result in violation of the ethical standards of his/her professional discipline.

There shall be a stated rationale for the provision of services to

be rendered to the client in the form of an identified objective or purpose.

The member shall refuse to participate in practices which are inconsistent with the standards established by regulatory bodies regarding the delivery of services to clients. Members will adhere to all tenets of confidentiality.

At the time of initial referral, the member has the responsibility for identifying to the referral source and to the client what services are to be provided and practices to be conducted. This shall include the identification, as well as the clarification, of services that are available by that member.

Professional Education, Training and Experience

NARPPS supports the principle of accreditation of member rehabilitation companies on a voluntary basis.

NARPPS considers the following standards to be the minimum requirements for the rehabilitation practitioner:

1. Professional Rehabilitation Practitioner

    a. Holder of a Masters or Doctorate degree in health-support services from an accredited institution, plus one year of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or diseases; or

    b. Holder of a Baccalaureate degree in health-support services from an accredited institution, plus two years of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or diseases; or

    c. Diploma in Nursing from an accredited institution, plus a current R.N. license, plus three years of experience in physical rehabilitation or vocational rehabilitation. At least one year shall have been spent in the rehabilitation of disabling conditions and/or diseases; or

d. Holder of any Baccalaureate degree other than listed in (b.) above from an accredited institution, plus three years of experience in vocational rehabilitation. At least two years shall have been spent in the rehabilitation of disabling conditions and/or disease.

2. Associate Rehabilitation Practitioner

Holder of an Associate degree or high school diploma, plus continuing education and five years experience in vocational rehabilitation, including counseling, evaluation and direct case services. Three of the five years shall have been spent in the rehabilitation of disabling conditions and/or diseases.

3. Rehabilitation Intern

An individual who meets the minimum education requirements but, does not meet the experiential requirements must be supervised by a professional rehabilitation practitioner. The intern shall provide the name of the professional rehabilitation practitioner under whose direct supervision he/she will work. The supervisor will function as the primary case manager.

Advocacy

Advocacy is a term used when referring to the act of pleading the cause or coming to the aid of another. NARPPS members respect the integrity and interest of the people and groups with whom they work. With regard to disabled persons, advocacy takes into account such issues as the legal rights of handicapped people to achieve integration into the social, cultural and economic life of the general community. The role of the NARPPS member as an advocate is to protect and promote the welfare of disabled persons to maximize control over circumstances that interfere with their obtaining vocational independence. When there is a conflict of interest between the disabled client and the NARPPS member's employing party, the member must clarify the nature and direction of his/her loyalty and responsibility and keep all parties informed of that commitment. NARPPS supports legislation that provides for services and care to the disabled.

Testimony

NARPPS recognizes that a rehabilitation practitioner has a responsibility, when requested, to provide objective testimony.

Rehabilitation practitioners provide services within the legal system and, in addition to providing primary care rehabilitation services, are called upon to testify as to facts of which they have knowledge or to render a professional opinion on rehabilitation questions or disability factors affecting an individual.

The testimony of a rehabilitation practitioner should be limited to the specific fields of expertise of that individual as demonstrated by training, education and experience. The extent of the practitioner's training, education and experience needed to testify is determined by the legal jurisdiction in which the practioner is testifying.

It is also permissible for a rehabilitation practitioner to render an expert opinion and answer questions about a disabled or handicapped indivivual that has been evaluated either in person or hypothetically.

Confidentiality

The purpose of confidentiality is to safeguard information that is obtained in the course of practice. Disclosures of information are restricted to what is necessary, relevant and verifiable with respect to the client's right to privacy. When a third party is involved, the key to confidentiality, when considering personal or confidential information, is to make certain the client is aware, from the outset, that the delivery of services is being observed by the third party. Professional files, reports and records shall be maintained under conditions of security and provision will be made for their destruction when appropriate.

Business Practices

Individuals and/or organizations in private sector rehabilitation should adhere to all applicable standards and practices common to the general business community. In addition, they should give special attention to and adhere to the following specific points:

1. Members will adhere to all applicable federal, state and local laws establishing and regulating business practices.

2. Members will not misrepresent themselves, their duties or credentials.

3. Members should carry professional liability insurance for the protection of themselves and affected third parties.

4. Rehabilitation practitioners shall not engage in claims practices as such are defined under the statutes and legal precedents in their respective jurisdictions.

5. It is to be encouraged that any discussion and comments or criticism directed toward a fellow rehabilitation practitioner or organization shall be positive and/or constructive.

6. Competitive advertising should be factually accurate and shall avoid exaggerated claims as to costs and results.

7. When asked to comment on cases being actively managed by another rehabilitation practitioner and/or organization, the reviewer shall make every reasonable effort to conduct an in-person evaluation before rendering his conclusion.

8. A rehabilitation practitioner member will not promise or offer services or results he cannot deliver or has reason to believe he cannot provide.

9. A member is not to solicit referrals either directly or indirectly by offering money or gifts other than de minimis gifts to a referral source.

10. When recruiting an employee, members should not falsely promise benefits, emoloyment advancement or salaries which they know or have reason to know that they cannot meet.

11. No rehabilitation practitioner or organization shall effectuate or participate in the wrongful removal of professional rehabilitation files or other materials upon the initiation, of new employment.

12. Rehabilitation practitioners shall not enter into fee arrangements that would be likely to create conflicts of interest or influence their testimony in claims cases. Rehabilitation practitioners shall advise the referral source/payor of its fee structure in advance of the rendering of any services and shall also furnish, upon request, detailed accurate time records.

13. Member referral sources working for member organizations or individuals shall pay invoices in accordance with normal payment practices.

CALIFORNIA ASSOCIATION OF REHABILITATION PROFESSIONALS STANDARDS (CARP)

Definition of a Vocational Rehabilitation Counselor

An individual practicing in the private sector, holding at least a Master's degree in rehabilitation counseling or in one of the behavioral sciences, including but not limited to sociology or psychology, and who has had two years experience using rehabilitation counseling techniques, vocational evaluation, psychological assessment, social, medical, vocational, and psychiatric information, in an agency (public or private), hospital, or clinic, in which the counselor was under professional supervision and has employed such methods and measures or who qualified for certification by the Commission of Rehabilitation Counselor Certification, can be considered a vocational rehabilitation counselor.

Associate Membership Consideration

Associate membership in CARP is open ONLY to those individuals who are interested or involved in the rehabilitation process, but are not involved in the competitive, private provider-of-services sector. This

means that associate memberships are open to those individuals or groups who are providing services through a public or nonprofit agency. Those providing services in the private sector have professional membership as their only alternative regardless of the size of the organization.

Upon receipt of your application form and fee, your name will be placed on the CARP mailing list. You will receive the monthly Newsletter and other mailings of importance during the fiscal year of your membership. Associate membership also entitles the holder to attend CARP sponsored workshops and seminars at the associate membership rate.

Counselor Competencies

The role of the rehabilitation counselor in assisting clients to choose an appropriate vocational goal and return to gainful employment demands responsibilities for competency and accountability.

Competencies are outlined and discussed throughout the professional literature. The following are CARP's guidelines and considerations for its members.

The rehabilitation counselor should have sufficient knowledge in the three areas of vocational diagnosis, counseling, and placement. Any one counselor may not be responsible for all of the three aspects of this rehabilitation process, but should be knowledgeable of each. The following is an outline of the responsibilities in each area.

Vocational Diagnosis

Basic Knowledge:

- Psychology
- Personality theory
- Vocational theory
- Medical and psychological aspects of disability
- Psychological and education testing
- Vocational evaluation
- Occupational information

Demonstrated by:

Collecting, analyzing, synthesizing, and interpreting information and data to formulate appropriate recommendations and vocational goals.

This conveys an awareness of what information is essential in the evaluation process as well as what resources are available to reach vocational goals.

Counseling

Basic Knowledge:

Intake interview
Establishing and maintaining an effective counseling relationship utilizing evaluation and vocational selfunderstanding
Problem solving techniques
Facilitating rehabilitation planning
Terminating a relationship

Demonstrated by:

Identifying and discussing with client and reports his/her vocational assests and liabilities and the means to complete the vocational rehabilitation process.

Placement

Basic Knowledge:

Employability behaviors
Sources of occupational information
Barriers to job placement of persons with disabilities
Job modification and restructuring procedures
Affirmative action laws
Effective job search skills
Labor market analysis
Job analysis

Demonstrated by:

Using occupational information
Developing a job placement file
Securing essential information from employers regarding job requirements and demands
Teaching job seeking skills
Identifying and matching employers and clients
Providing follow-up counseling with clients
Providing follow-up contacts with employers

The competencies identified above are basic to the rehabilitation counselor professional in facilitating the vocational rehabilitation process.